MASSACHUSETTS Health & Hospital ASSOCIATION

Surprise Billing: Federal and State Updates

Wednesday, December 8, 2021 | 11:30 a.m. – 12:30 p.m. ET

Karen Granoff

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Questions?
Technical Difficulties?

Contact MHA's Lindsay Goldfarb:
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Surprise Billing: Federal and State Updates

Wednesday, December 8, 2021 | 11:30 a.m. – 12:30 p.m. ET

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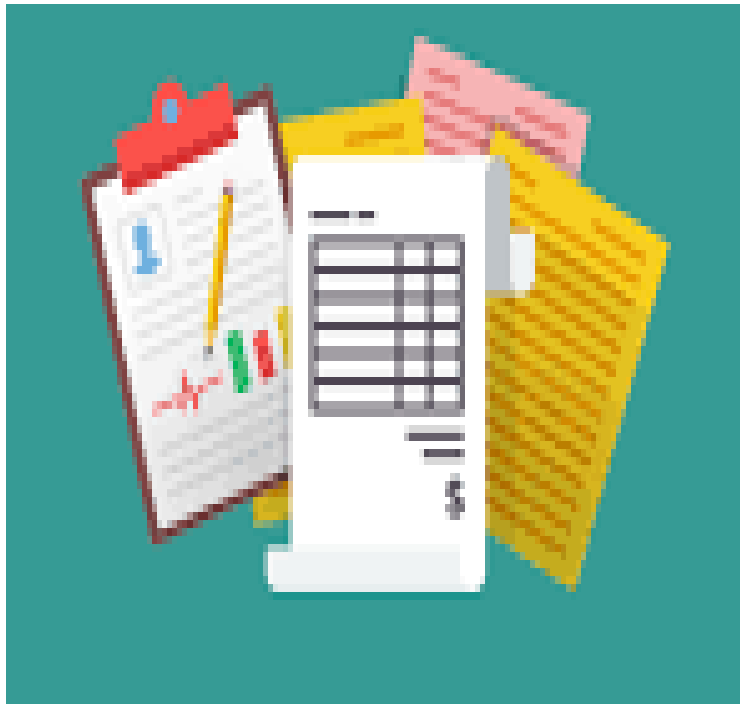
Surprise Billing: Federal Update

Massachusetts Health & Hospital Association and the Massachusetts Medical Society Webinar

December 8, 2021

Agenda for Discussion Today

- ✓Update on No Surprises Act regulations taking effect January 1, 2022
  - ✓Ban on Balance Billing and IDR Process to Resolve Payment Disputes
  - ✓Notice and Consent Process for Certain Out-of-Network Services
  - ✓Disclosure Requirements
  - ✓Good Faith Estimates
  - ✓Patient-Provider Dispute Resolution Process



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Implementation Key Dates – Major Provisions

Already In Effect

- Independent dispute resolution process (for purposes of selecting IDR entities)
- Provider/patient dispute resolution process (for purposes of selecting SDR entities)

Effective January 1, 2022

- Ban on balance billing in certain scenarios, notice and consent provisions
- Independent dispute resolution process, provider/patient dispute resolution process
- Good faith estimates*
- Provider directories**
- Continuity of care**

*Subject to enforcement discretion for these estimates for insured patients, as well as for consolidated estimates for uninsured/self-pay, until further guidance is provided

**Subject to enforcement discretion until further guidance is provided

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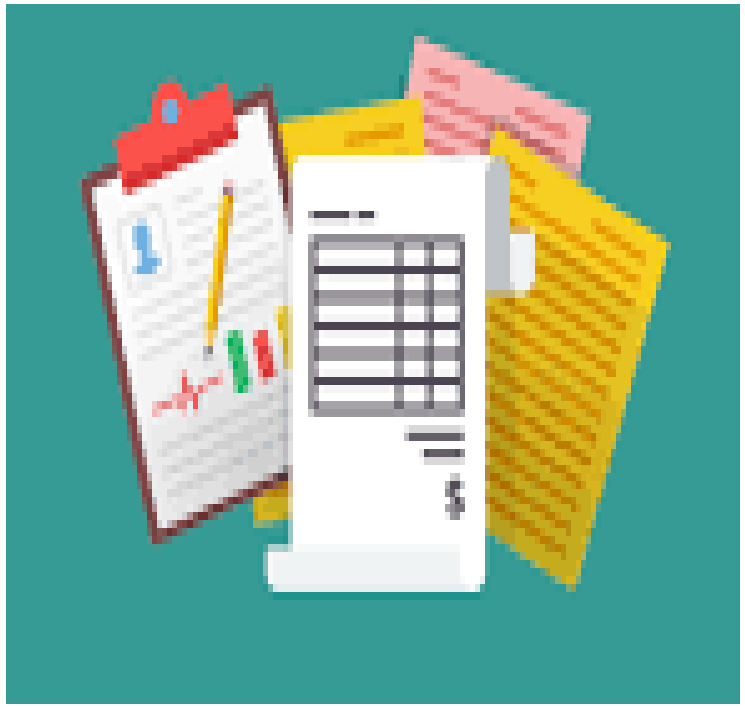

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Patient Protections Against Balance Billing

- **As of January 1, 2022, providers/facilities <u>may not balance bill</u> out-of-network patients for:**
  - Emergency services, including certain services post-stabilization
  - Professional services when delivered at in-network facilities
  - In *some* instances, providers may seek patient consent to balance bill

Ban does not apply to scheduled services when both the facility and provider are out-of-network.

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Patient Protections Against Balance Billing

- **Providers <u>may not balance bill</u> out-of-network patients in certain scenarios:**
  - Emergencies
  - The following scheduled services provided at an in-network facility:
    - Items or services delivered as a result of an unforeseen urgent medical issue arising during a procedure for which notice and consent was received
    - Anesthesiology
    - Pathology
    - Radiology
    - Neonatology
    - Diagnostic (radiology and laboratory)

- **Patient cost-sharing will be determined by a formula established by HHS**

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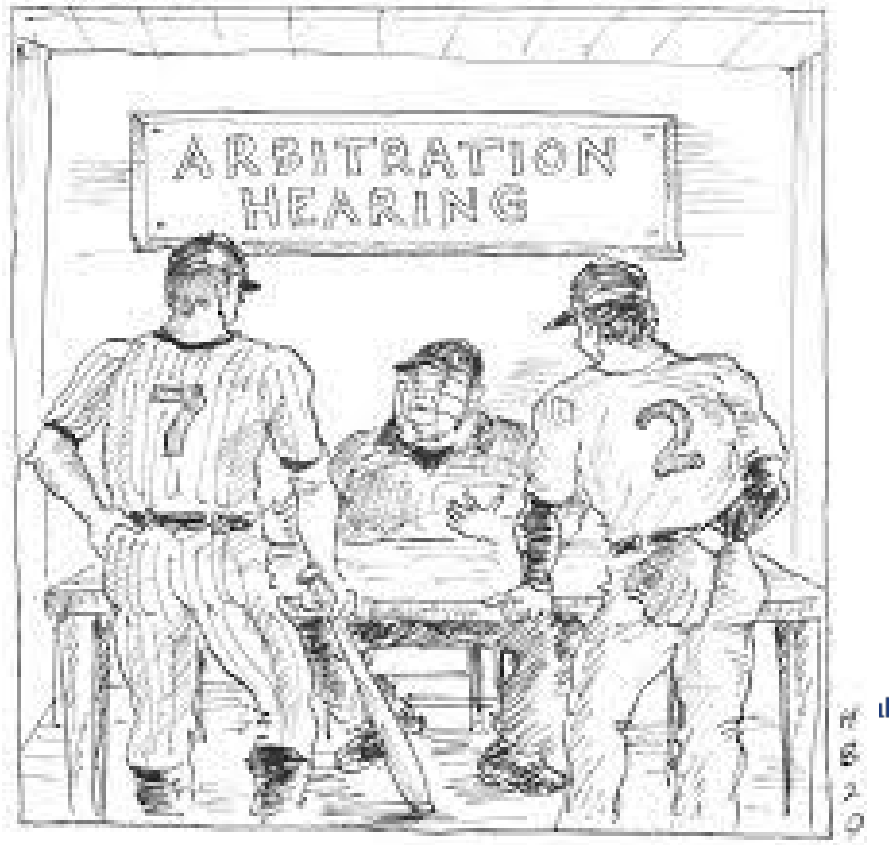
Independent Dispute Resolution (IDR) Process

- Available if negotiations between a provider/plan fail
- “Baseball style” arbitration… each party submits best and final offer
- Arbiters can take into account a number of different factors when making a selection
- Decision is binding
- Loser pays
- Limits on bringing similar cases back to arbitration within 90 days
- Batching of similar claims permitted



Independent Dispute Resolution Process

Process Step	Timetable	Initiating Party	Required Notices
Initial Payment or Payment Denial	Within 30 days of receipt of clean claim from provider.	Plan/Issuer	Not Applicable
Open Negotiation Period	Within 30 business days of receipt of initial payment or payment denial, notice is to be sent. Open Negotiation Period last 30 business days	Provider	Open Negotiation Notice (dol.gov)
Initiation of IDR	Within 4 business days of the end of the Open Negotiation Period.	Either party. Initiating party must send notice to opposing party. Notice must also be sent to the Federal IDR Portal	surprise-billing-part-ii-information-collection-documents-attachment-3.pdf (dol.gov)
Selection of Certified IDR Entity	Within 3 business days following IDR initiation, selection of certified IDR entity is to be made. Notice of selection must be sent within 4 business days to Federal IDR Portal.	Initiating party selects IDR entity. Opposing party may object.	Appendix 1: Federal Independent Dispute Resolution (IDR) Process: Selection of Certified IDR Entity (dol.gov)
Selection of IDR Entity by Government if Parties fail to Select	Within the 6 business days of IDR initiation, Government will randomly select certified IDR Entity	Government	Not Specified
Certified IDR Entity Review for Conflict of Interest	Within 3 business days of selection, IDR entity must attest they meet conflict of interest standards or notify Government.	Certified IDR Entity	Federal IDR Portal
Certified IDR Determines if IDR process applies to disputed claim(s)	Within 3 business days of determination, IDR entity notifies parties.	Certified IDR Entity	Not Specified
Disputing Parties Agree to OON Payment Rate after initiation of IDR Process	Anytime after the initiation of the IDR process.	Both Disputing Parties	Appendix 2: Federal Independent Dispute Resolution (IDR) Process: Notice of Agreement Data Elements (dol.gov)
Submission of Offers by disputing parties if no agreement is reached	Within 10 business days of IDR Entity selection	Both Disputing Parties	Appendix 3: Federal Independent Dispute Resolution (IDR) Process Notice of Offer (dol.gov)
IDR Entity Selection of Offer and Written Decision	Within 30 business days of IDR Entity selection	Certified IDR Entity	Appendix 6: Certified IDR Entity's Written Decision of Payment Determination Data Elements (dol.gov)
Payment Upon Final IDR Entity Determination	Within 30 calendar days after IDR entity determination	Party that owes based on determination	Not Applicable
"Cooling Off Period" period for which no further claims maybe submitted for IDR Review	90 calendar days after IDR Entity initial payment determination	Initiating party	Not Applicable
Request for Time Extensions	Submit request to Government because of extenuating circumstance	Both disputing parties	surprise-billing-part-ii-information-collection-documents-attachment-10.pdf (dol.gov)
Petition for Denial of Certification of IDR Entity and Decertification of Current Certified IDR Entity	For IDR entities seeking certification, petitioners have 5 business days after the Government posts list of the IDR entities applying for certification. For currently certified IDR entitles, petitioners timetable to file revocation petition is open-ended.	An individual, provider, facility, provider of air ambulance services, plan or issuer may petition Government	Petition to Deny or Revoke IDR Certification: Instructions (dol.gov)

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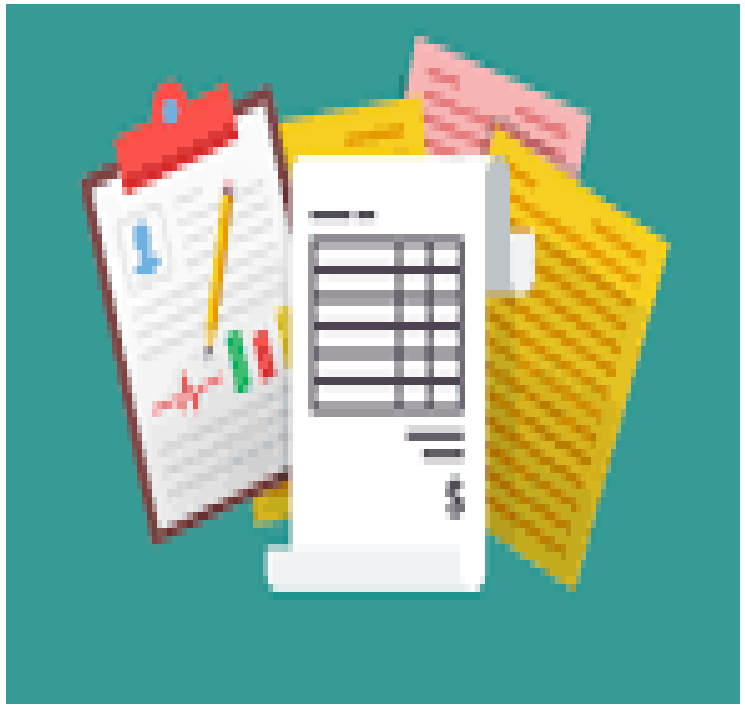
  - ✓Good Faith Estimates
  - ✓Patient-Provider Dispute Resolution Process



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Providing Notice and Obtaining Consent for Patient to Waive Balance Billing Protections

- The law permits patients to waive balance billing protections if the out-of-network provider obtains the patient's consent in two narrowly prescribed circumstances:
  - 1) post-stabilization, and
  - 2) certain scheduled services provided by an out-of-network provider at an in-network facility.

Consent does not extend to items or services that are delivered as a result of an unforeseen urgent medical need that arises during a procedure for which consent was received.

Post-stabilization: Conditions to Transfer, Provide Notice and Obtain Consent

Post-Stabilization Patients may waiver their rights to balance billing protections in limited circumstances when the following conditions are met:

1. Treating physician or provider determines that the patient can travel to an in-network facility using non-medical or non-emergency medical transportation.
2. Determination must be based on all relevant factors, including the type of available transportation, travel distance, travel conditions and the patient's ability to pay for such transportation;
3. Treating physician or provider determines if the individual or the individual's personal representative is able to provide informed consent and, in doing so, must take into account factors such as a patient's mental and emotional state, mental or behavioral conditions, substance use, language access and literacy levels, and cultural or other contextual factors, including historical inequities for underserved communities. The individual must be able to consent freely, voluntarily and without undue influence, fraud, or duress;
4. Providers or facilities must satisfy all other conditions regarding notice and consent such as good faith estimates and list of in-network providers able to deliver service if facility is in-network
5. Providers and facilities must comply with any relevant state law, including laws that prohibit patients from waiving balance billing protections.

Decision of the treating physician or provider in assessing whether the post-stabilization conditions are met is binding on the facility.

Notice and Consent: Process General Requirements

- As noted, consent is only an option for certain types of providers and types of services
- Patient must be able to freely give consent
- Providers must adhere to certain timelines and use a standard form
- Providers must retain forms for a certain period of time and share the forms with both the patient and their health plan (which facilities may do for providers upon mutual agreement)
- Providers must notify plans when balance billing protections apply for a service and when notice and consent is used.

Once given, a patient may revoke their consent in writing and before the item or service is delivered.

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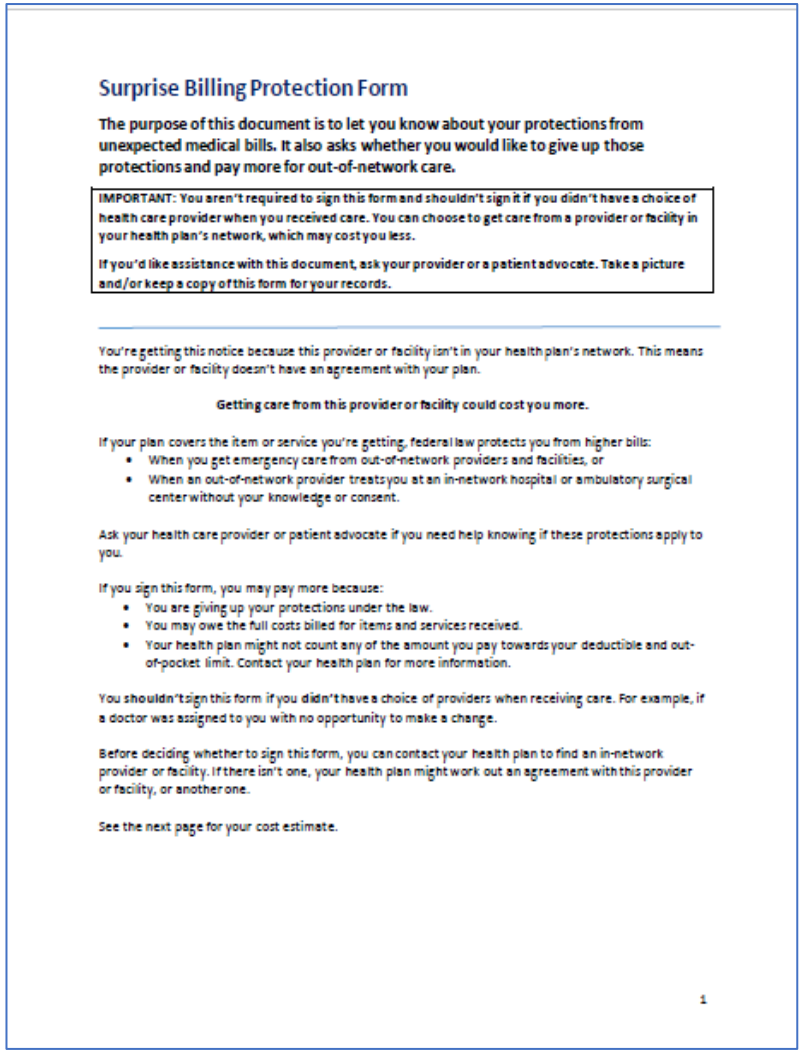
Limits on Providing Notice and Obtaining Consent

Consent cannot be used for:

- X Items and services related to emergency medicine, anesthesiology, pathology, radiology and neonatology, whether provided by a physician or non-physician practitioner;
- X Items and services provided by assistant surgeons, hospitalists and intensivists;
- X Diagnostic services, including radiology and laboratory services; and
- X Other items and services provided by a nonparticipating provider if there is no participating provider who can furnish such items or services at such facility.

Consent does not extend to items or services that are delivered as a result of an unforeseen urgent medical need that arises during a procedure for which consent was received.

Standard Notice and Consent Forms Provided by HHS



Surprise Billing Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

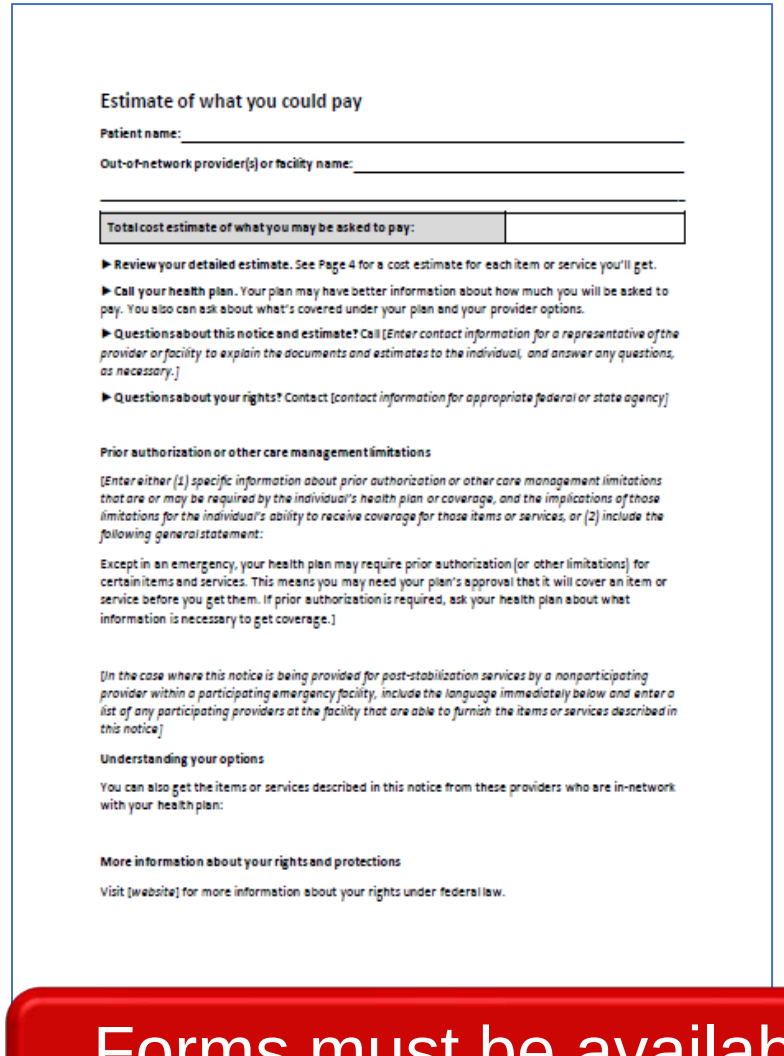
- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

You **shouldn't** sign this form if you **didn't** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

See the next page for your cost estimate.

1



Estimate of what you could pay

Patient name: _____

Out-of-network provider(s) or facility name: _____

_____

Total cost estimate of what you may be asked to pay:	

►Review your detailed estimate. See Page 4 for a cost estimate for each item or service you'll get.

►Call your health plan. Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.

►Questions about this notice and estimate? Call *[Enter contact information for a representative of the provider or facility to explain the documents and estimates to the individual, and answer any questions, as necessary.]*

►Questions about your rights? Contact *[contact information for appropriate federal or state agency]*

Prior authorization or other care management limitations

[Enter either (1) specific information about prior authorization or other care management limitations that are or may be required by the individual's health plan or coverage, and the implications of those limitations for the individual's ability to receive coverage for those items or services, or (2) include the following general statement:

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.*]*

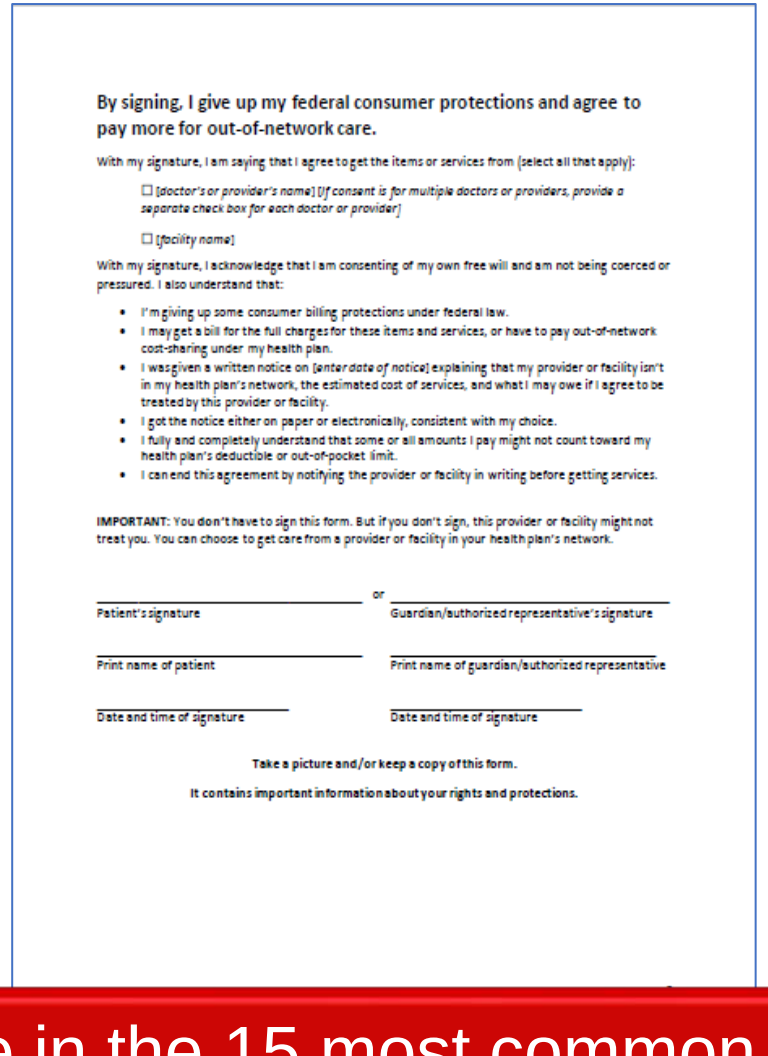
[In the case where this notice is being provided for post-stabilization services by a nonparticipating provider within a participating emergency facility, include the language immediately below and enter a list of any participating providers at the facility that are able to furnish the items or services described in this notice]

Understanding your options

You can also get the items or services described in this notice from these providers who are in-network with your health plan:

More information about your rights and protections

Visit *[website]* for more information about your rights under federal law.



By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from (select all that apply):

☐ *[doctor's or provider's name] [If consent is for multiple doctors or providers, provide a separate check box for each doctor or provider]*

☐ *[facility name]*

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on *[enter date of notice]* explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You don't have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

_____ or _____

Patient's signature — Guardian/authorized representative's signature

_____ _____

Print name of patient — Print name of guardian/authorized representative

_____ _____

Date and time of signature — Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

Forms must be available in the 15 most common languages in the provider's area.

Notice and Consent: Timeline & Process

- Notice and Consent must be sought at least 72 hours before the service or treatment is to be delivered.
- For same-day services, notice and consent must be sought at least three hours prior to receiving the service or treatment.
- Providers/facilities must convey the forms to the patient separately from other documents.
- A copy of the signed notice and consent form must be provided to the patient or authorized representative in a form of their choosing.
- In addition, a representative of the provider/facility must be available to answer questions.

Disclosure Requirements

- Providers and facilities must make publicly available information on patients' rights with respect to balance billing, including through a notice to patients.

Public Notice

✓posted on website

✓contain information on federal balance billing protections and applicable state-level protections

✓include contact information for state and federal agencies to report any potential violations.

Patient Notice

✓one page notice to patients when provider or facility asks for payment or submits a claim

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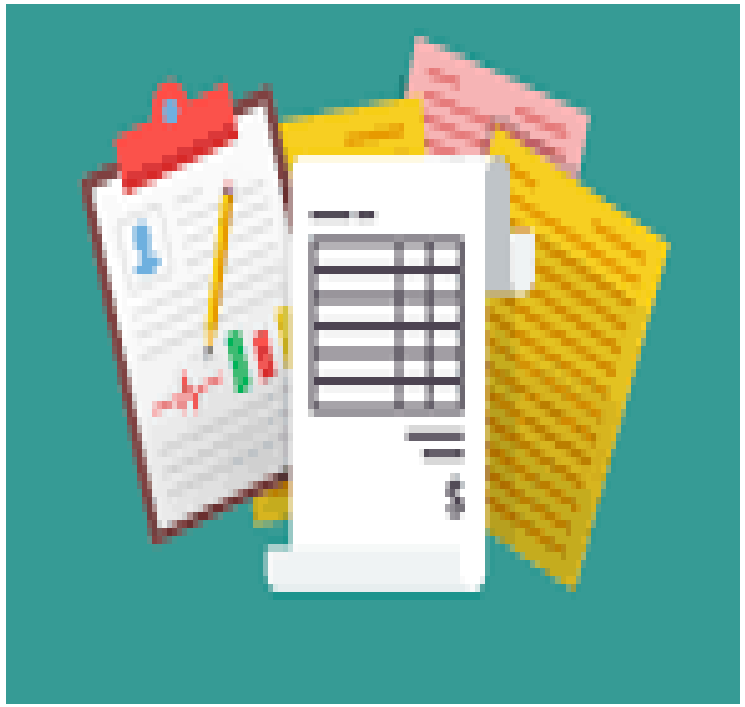

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Key Takeaways: Good Faith Estimates for Uninsured/ Self-Pay Patients

- Good faith estimates required for **all** uninsured/self-pay scheduled services (3+ days out) AND when requested by a uninsured/self-pay patient
- One provider (***"convening provider"***) required to coordinate estimates across all providers and deliver one good faith estimate to the patient
- The good faith estimate should cover all items/services from admission to discharge (e.g., all items/services that wouldn't be scheduled on their own)
- The estimates should be the **cash pay rate or uninsured/self-pay rate, reflective of any discounts** available to the patient (e.g., financial assistance)

Convening Provider is defined as the provider/ facility responsible for scheduling the primary item/service or that receives the request for an estimate; they will **not** be responsible for the accuracy of other provider's estimates

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Delivery Timeline for Good Faith Estimate for Uninsured/Self-Pay Patients

Service Scheduled	Deadline to Return Estimate to Patient
3-9 days in advance	1 business day after scheduling/request
10+ days in advance OR by request (service not scheduled)	3 business days after scheduling/request

The convening provider must request good faith estimates from the co-providers within one business day; the request must include a deadline for when the convening provider would like the co-providers to responds

HHS will delay enforcement of the requirement that the good faith estimates include the co-provider estimates until 1/1/23.

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Patient-Provider Dispute Resolution Process

Uninsured/self-pay patients can initiate the patient-provider dispute resolution process in instances when a provider or facility's total bill is **$400+** more than the provider or facility's total good faith estimate.

PROVIDER 1			
Service	Good Faith Estimate	Billed Amount	Difference
Service A	$500	$600	$100
Service B	$1,000	$1,000	-
Service C	-	$100	$100
TOTAL	**$1,500**	**$1,700**	**+$200**

PROVIDER 1			
Service	Good Faith Estimate	Billed Amount	Difference
Service A	$500	$600	$100
Service B	$1,000	$1,000	-
Service C	-	$500	$500
TOTAL	**$1,500**	**$2,100**	**+$600**

Each provider is responsible for the accuracy of their own estimates.

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Questions?
Comments?

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Thanks!

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Understanding the Massachusetts Out of Network Billing Law

December 8, 2021

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Legislative Attention to OON Billing

- Over the last several years, both the federal government and a number of state legislatures have sought to find a solution to OON status and billing.
- Federal No Surprises Act signed into law in December 2020, and the first set of implementing rules were released by the Biden Administration on July 1, 2021. (*See* prior presentation)
- Mass law G.L. Ch. 111 Sec. 228 was revised by Acts of 2020, Chapter 260, Section 25 (approved January 1, 2021)
-

Agenda

1. Introduction to Massachusetts's OON Billing Law
2. Prior Requirements Under MGL Ch. 111 s. 228
3. What are Health Care Providers required to do under the new Massachusetts law?
4. Penalties & Effective Date
5. Discussion

Introduction to the Massachusetts's OON Billing Law

Acts of 2020, Chapter 260 Section 25 (Approved January 1, 2021)

Key differences: Who does the law apply to?

- Unlike the federal law, which regulates OON through health plans, the Massachusetts law regulates ***providers.***
  - "Health care provider" means any doctor of medicine, osteopathy, or dental science, or a registered nurse, social worker, doctor of chiropractic, or psychologist licensed under the provisions of chapter one hundred and twelve, or an intern, or a resident, fellow, or medical officer licensed under section nine of said chapter one hundred and twelve, or a hospital, clinic or nursing home licensed under the provisions of chapter one hundred and eleven and its agents and employees, or a public hospital and its agents and employees ("HCP"). G.L. Ch. 111 s. 1.

Prior Requirements Under G.L. Ch. 111 s. 228

Prior Requirements

- Before an admission, procedure or service and upon request by a patient or prospective patient, a HCP must, *within 2 working days, disclose the allowed amount or charge of the admission, procedure or service, including the amount for any facility fees required*; provided, however, that if HCP is unable to quote a specific amount in advance due to the HCP's inability to predict the specific treatment or diagnostic code, the HCP shall disclose the *estimated maximum allowed amount* or charge for a proposed admission, procedure or service, including the amount for any facility fees required.
- If a patient or prospective patient is covered by a health plan, a *HCP who participates as a network provider shall, upon request* of a patient or prospective patient, *provide*, based on the information available to the provider at the time of the request, *sufficient information regarding the proposed admission, procedure or service for the patient or prospective patient to use the applicable toll-free telephone number and website of the health plan established to disclose out-of-pocket costs*, under section 23 of chapter 176O. A health care provider may assist a patient or prospective patient in using the health plan's toll-free number and website.

What are Health Care Providers required to do under the new Massachusetts law?

Notice of Status with Health Plans

- When scheduling an admission, procedure or service for a patient or prospective patient ("PP") for a condition that is not an "emergency medical condition" or upon request by a patient or PP, *HCP must disclose whether the provider is participating in the patient's health benefit plan*.
- For a continued course of treatment (including subsequent admissions, procedures or services) the patient/PP may waive disclosure requirement – but only if the provider is in network.
- HCP must notify if HCP's status with the health benefit plan changes during a continued course of treatment.

➢ Health benefit plan vs product? Narrow networks? Impact on patient's change of plan?

What is an “emergency medical condition”?

- The notification is not required in the event of an “emergency medical condition”, which is defined as:
  - “a medical condition, whether physical, behavioral, related to substance use disorder, or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the insured or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in [EMTALA].” M.G.L. c. 1760, s.1.
  - Potentially broader than the EMC def. in EMTALA

What is an “Allowed Amount”?

- “Allowed amount” means the “contractually agreed-upon maximum amount paid by a carrier to a health care provider for a health care service provided to an insured.”
  - Same definition as in current law

Requirements for Participating HCPs

- If HCP **is participating** in the patient's or PP's health benefit plan, then, at the time of scheduling, the HCP must:
  - (i) *inform the patient/PP that may request disclosure of the allowed amount and the amount of any facility fees for the admission, procedure or service*; and
  - (ii) inform the patient/PP that the patient or PP *may obtain additional information about any applicable out-of-pocket costs*;
  - If patient/PP makes a request under clause (i) above, *a HCP shall disclose the allowed amount and the amount of any facility fees for the admission, procedure or service not later than 2 days after receipt of such request*.
  - If a HCP is *unable to quote a specific amount in advance due to the HCP's inability to predict the specific treatment or diagnostic code, the HCP must disclose the estimated maximum allowed amount* and the amount of any anticipated facility fees.

Requirements for Non-Participating HCPs

- If the HCP is ***not*** **participating** in the patient's or PP's health benefit plan, the HCP must, at the time of scheduling:
  - (i) *provide the charge and the amount of any facility fees for the admission, procedure or service*;
  - (ii) inform the patient or PP that *the patient or PP will be responsible for the amount of the charge and the amount of any facility fees for the admission, procedure or service* not covered through the patient's health benefit plan; and
  - (iii) inform the patient or PP that the patient or PP *may be able to obtain the admission, procedure or service at a lower cost from a HCP who participates in the patient's or PP's health benefit plan*. A HCP may assist a patient or PP in using the patient's or PP's health plan's toll-free number and website.
  - ➢ No option to provide an estimated maximum allowed amount?

Use of Insurer's toll-free number and website

- Statue permits, but likely does not require, health care providers to assist patients or PPs in using the patient's insurance company's toll-free number and website.

Obligations of Referring HCP (*prior law*)

A HCP referring a patient to another provider must disclose if the referral is to a provider part of or represented by the “same provider organization”

- “**Provider organization**” means any corporation, partnership, business trust, association or organized group of persons, which is in the business of health care delivery or management, whether incorporated or not that represents 1 or more health care providers in contracting with carriers for the payments of heath care services; provided, that "provider organization" shall include, but not be limited to, physician organizations, physician-hospital organizations, independent practice associations, provider networks, accountable care organizations and any other organization that contracts with carriers for payment for health care services.

Obligations of a Referring HCP (cont.)

A HCP referring a patient to another provider must also disclose:

- *the possibility that the provider to whom the patient is being referred is not participating in the patient's health benefit plan* and
- that if the provider is out-of-network under the terms of the patient's health benefit plan, then any out-of-network applicable rates under such health benefit plan may apply and that the patient has the opportunity to verify whether the provider participates in the patient's health benefit plan prior to making an appointment or agreeing to use the services of said provider.

- Does "referral" include requests for consultations? Specialists consulted during an inpatient stay?
- What about when patients fearful of the disclosure refuse a necessary consult?

Obligations of a Referring HCP (cont.)

HCP referring a patient to another provider must also disclose:

- *sufficient information about the referred provider for the patient to obtain additional information about*
  - *the provider's network status under the patient's health plan* and
  - any applicable out-of-pocket costs for services sought from the referred provider pursuant to health insurance consumer protection laws, MGL c. 176O s. 23.

Obligations for Referring HCPs that "directly schedule"

- Before a HCP refers a patient to another provider *by directly scheduling, ordering or otherwise arranging for the health care services on the patient's behalf,* the HCP **must**:
  - (i) verify whether the provider participates in the patient's health benefit plan; and
  - (ii) notify the patient if that provider does not participate in the patient's health benefit plan or if the network status of could not be verified.

➢ What does "directly scheduling" mean?

Additional Notice Requirements

- *A HCP shall determine if it participates in a patient's health benefit plan prior to patient's admission, procedure or service for conditions that are not emergency medical conditions*.

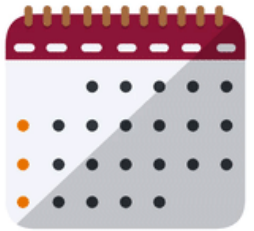
➢ What about patients who are uncertain about their plan status?

Additional Notice Requirements

- If the HCP *does not participate* in the patient's health benefit plan and the admission, procedure or service was scheduled more than 7 days in advance of the admission, procedure or service, *such provider shall notify the patient verbally and in writing of that fact not less than 7 days before the scheduled admission, procedure or service*.
  - (if scheduled less than 7 days in advance, notify the patient verbally of that fact not less than 2 days before or as soon as is practicable before the scheduled admission, procedure or service, with written notice upon the patient's arrival at the scheduled admission, procedure or service.

Date Calculation

- As the term “day” is undefined in the statute, the default definition under Massachusetts Law is calendar day:
  - “The word 'day' when not qualified means a calendar day...And a calendar day is the space of time that elapses between two successive midnights” Booker v. Chief Engineer of the Fire Department of Woburn, 324 Mass. 264 (1949).
  - When day for an act falls on a Sunday, may be performed on the next succeeding business day (G.L. Ch. 4, Sec. 9)



Billing Limitation if Notice Not Provided

- *If a HCPthat does not participate in the patient's health benefit plan fails to provide the required notifications under this subsection, the provider* ***shall not bill the insured except for any applicable copayment, coinsurance or deductible that would be payable if the insured received the service from a participating HCP****under the terms of the insured's health benefit plan*.

- Providers should continue to bill the Plan for the balance of the OON benefit. Patients won't have to pay full charge. (query how billing for a deductible will operate.)
- Beware/challenge any health plan refusal to pay OON benefit based on this language. (Nothing in this language says the plan may refuse to pay, only that the provider may not charge the insured.)

Billing Limitations cont.

- Refraining from billing alone *does not* relieve the health care provider from compliance with the remaining notice requirements in the law.
- A health care provider who does not participate in a patient's plan *and* does not provide verbal and written notice to the patient within the applicable time frames *may be subject to penalty imposed by the Commissioner of the Department of Public Health as well as the billing prohibition*.

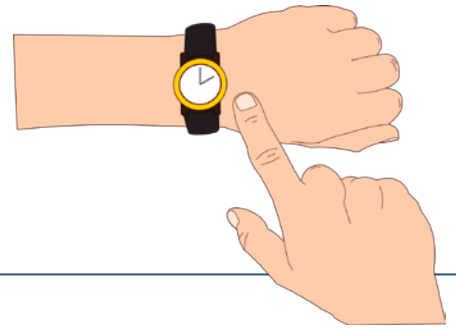
Penalties and Effective Date

Penalties for Providers

- The statute states that “the commissioner shall implement [the new law] and impose penalties for non-compliance”, including inability to bill differently from in-network.
- The penalty will not exceed $2,500 in each instance.
- Penalties are not effective until January 1, 2022.

When is the new law effective?

- Unclear, but the on-line version of the General Laws was recently updated to reflect:
  - Before subsections (a)-(d): "*[Text of section through subsection (e) amended by 2020, 260, Sec. 25 effective January 1, 2021. For text effective until January 1, 2021, see above.]*"
  - And before subsection (f) – regarding implantation and penalties: "*[Balance of text as amended by 2020, 260, Sec. 25 effective January 1, 2022. See 2020, 260, Sec. 75.]*"



When is the new law effective?

- Despite on-line interpretation, strong argument that Sec. 228 is not self-implementing and that notice and comment rulemaking (regulations) are needed to implement the statute. (subsection (f))
  - "the commissioner *shall implement this section and impose penalties for non-compliance consistent with the department's authority to regulate health care providers*" (emphasis added);
  - specific reference to "rules and regulations adopted pursuant to this subsection"
- Chapter 260, Sec. 75. "Subsection (f) of section 228 of chapter 111 of the General Laws shall take effect on January 1, 2022."

Regulatory clarifications?

- DPH has signaled that:
  - May not be implementing regulations prior to January 1, 2021
  - Statute may go into effect on 1/1/2021 pursuant to its terms
  - No clarification of ambiguities (despite language quoted on prior slide regarding implementation)
- MHA and MMS are in ongoing discussions with DPH

Discussion

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Questions?

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2022 Joint Commission Update

Thursday, January 13, 2022
8:30 – 11 a.m.

For all MHA Education Programs

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