DOCTORS' RESOURCE SPECIALISTS

Client Memo
December 2021

"Celebrate endings, for they precede new beginnings."
– Jonathan Huie

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No Surprises Act

The No Surprises Act, part of the Consolidated Appropriations Act of 2021, goes into effect January 1, 2022. The interim rule restricts out-of-network billing and protects patients from excessive costs should they receive care from providers that are not on their insurance plans.

On July 1, 2021, Health and Human Services (HHS) issued the first in a series of regulations that would restrict excessive out of pocket costs to consumers from surprise billing and balance billing.

Part 2 was issued on September 30, 2021, and covers legislation that regulates surprise/balance billing in healthcare settings. This includes the federal Independent Dispute Resolution (IDR) process to determine the out-of-network rate for applicable services after an unsuccessful open negotiation.

Part 3 was issued on November 17, 2021, and is currently open for public comment. This interim rule covers prescripttion drug and health care spending.

As stated on the HHS website, surprise billing happens when people unknowingly get care from providers that are outside of their health plan's network and can happen for both emergency and non-emergency care.

Balance billing, when a provider charges a patient the remainder of what their insurance does not pay, is currently prohibited for both Medicare and Medicaid. This rule will extend similar protections to Americans insured through employer-sponsored and commercial health plans."

The rule includes the following provisions:

- Bans surprise billing for emergency services. Emergency services, regardless of where they are provided, must be treated on an in-network basis without requirements for prior authorization.
- Bans high out-of-network cost-sharing for emergency and non-emergency services. Patient cost-sharing, such as co-insurance or a deductible, cannot be higher than if such services were provided by an in-network doctor, and any coinsurance or deductible must be based on in-network provider rates.
- Bans out-of-network charges for ancillary care (e.g. an anesthesiologist or assistant surgeon) at an in-network facility in all circumstances.
- Bans other out-of-network charges without advance notice. Health care providers and facilities must provide patients with a plain-language consumer notice explaining that patient consent is required to receive care on an out-of-network basis before that provider can bill at the higher out-of-network rate.

A standard notice and consent form for nonparticipating providers can be obtained by going to: https://www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf

The following out-of-network providers practicing in in-network facilities are exempt from the notice and consent requirement:

- Radiologists
- Pathologists
- Emergency Medicine
- Anesthesiologists
- Diagnostic services
- Neonatologists
- Assistant Surgeons
- Hospitalists
- Intensivists
- Providers offering services when no other in-network provider is available.

(Additional details regarding the rule and how it will be applied are still forthcoming as the new rule goes into effect for 2022. The information presented here covers only what is known at this time).

Kelly Noyes. J.D., with von Briesen & Roper, s.c., discusses the provisions of the new rule in her October 19, 2021, article, "Surprise! It's the No Surprises Act," for *the National Law Review.*

While many details of the No Surprises Act are still forthcoming as federal agencies engage in the necessary rule-making (which may not be complete by the Act's effective date), health care providers, facilities, insurers, and health plans should act now to ensure they are ready to comply with the Act's requirements, writes Ms. Noyes.

The No Surprises Act allows patients to waive its protections with regard to certain non-emergency services only, but there are strict notice and consent requirements that apply. These requirements make it clear that Congress's intention is that waiver of the No Surprises Act protections and consent to payment of out-of-network fees should be the exception for patients, rather than the rule.

If a patient declines to waive the No Surprises Act protections, an out-of-network provider can refuse to provide treatment, unless there is no in-network option, or there is another law barring such a refusal. However, the provider cannot pressure a patient into waiving his or her rights, for example, by delaying necessary treatment, or charging cancellation fees for existing appointments.

What do health care providers and facilities need to do?

Public Disclosures -- health care facilities and providers are required to provide – to both the public and patients with applicable health plans – a one-page disclosure providing a plain-language explanation of the No Surprises Act and its requirements. The disclosure must give patients:

- a clear and understandable statement of the requirements and prohibitions of the No Surprises Act; and
- information regarding the process through which patients can complain about alleged violations.

No balance billing out-of-network patients -- facilities and providers must determine what patients are in-network versus out-of-network, and negotiate any payment amounts for out-of-network care with the patient's health plan, rather than billing the patient and requiring the patient to negotiate with the plan.

Where applicable, obtain the necessary written waiver -- If a provider seeks to have a patient waive the No Surprises Act's protections, the provider has to give the patient a detailed written consent form at least 72 hours prior to a scheduled appointment, or 3 hours before a same-day appointment.

The existing regulations require that the consent form be provided to the patient separate from other forms, and indicate:

(a) whether pre-authorization is required;
(b) what in-network providers are available; and
(c) a good-faith cost estimate for the total bill for the proposed out-of-network care. (The good faith cost estimate also triggers health plans to provide an advanced explanation of benefits, giving patients information regarding not just the total cost of the out-of-network care, but the patient's likely out-of-pocket expenses.

What do facilities and providers get paid for out-of-network care?

There are two components to the payments provided to out-of-network facilities and providers under the No Surprises Act:

1. Patient Payments -- Under the No Surprises Act, patient payments are limited to the patient's cost-sharing requirement for in-network care. This means, for example, that if a patient's health plan has a 20% coinsurance requirement for in-network emergency care, that same 20% requirement applies to the out-of-network emergency care.

2. Health Plan Payments -- The second component of the payment to facilities or health care providers is the health plan's payment. Health plans must pay the facility or provider the total amount the plan believes it owes within 30 days of receiving a clean claim.

The No Surprises Act provides that insurance payments can be based on an All-Payer model, state law, an agreement between the plan and the facility or provider, or a resolution decided by an arbitrator through the independent dispute resolution process. Wisconsin does not recognize an all-payer model.

If the health care facility or provider enters into negotiations and cannot reach a resolution within 30 days, the facility or provider then has four days to initiate independent dispute resolution regarding the payment amount.

Independent Dispute Resolution (IDR) -- If a health care facility or provider initiates the IDR process, both the facility or provider and the health plan will submit to an arbitrator a proposed payment amount, and information regarding the following factors:

- The calculated Qualified Payment Amount (QPA);
- The provider's training and experience;
- The complexity of the procedure or medical decision-making;
- The patient's acuity;
- The market share of the health plan, and the provider or facility;
- Whether the care was provided at a teaching facility;
- The scope of services;
- Any demonstration of good faith efforts to agree on a payment amount; and
- The contracted rates from the prior year.

Many details about the IDR process related to health plan payments for out-of-network services are still forthcoming, including what weight arbitrators should give to each of the factors provided.

How is the No Surprises Act going to be enforced?

States will have primary enforcement authority for the No Surprises Act for both issuers who offer health insurance coverage in the individual or group markets in the state, and facilities or providers offering services in the state. If the state does not provide adequate enforcement, CMS will take over enforcement.

With regard to health plans, CMS and states may conduct random, targeted, market conduct investigations to ensure compliance.

The No Surprises Act imposes civil monetary penalties of up to $10,000. The penalty will be waived if a provider or facility did not knowingly violate, and should not have reasonably known it violated, the act, and reimburses any incorrect payments plus interest. There is also a hardship exemption to the civil monetary penalties.

More detailed Information on the No Surprises Act can be viewed at: https://www.cms.gov/nosurprises

CMS Releases Final Rule for 2022

The 2022 Medicare Physician Fee Schedule final rule promotes greater telehealth utilization and boosts payment rates for vaccine administration, writes Jacqueline LaPointe in her November 3, 2021, article for *RevCycle Intelligence.*

The conversion factor for next year will be $33.59, a decrease of $1.30 versus the 2021 conversion factor. Next year's rate accounts for statutory changes to RVUs and the expiration of the 3.75% temporary 2021 payment increase Congress approved through pandemic-related legislation.

Other finalized policies include the elimination of geographic barriers when it comes to using telehealth for behavioral healthcare. The final rule enables patients to access telehealth services in their homes versus a qualifying healthcare site for diagnosis, evaluation, and treatment of mental health disorders.

The Medicare Physician Fee Schedule will pay for mental health visits furnished by rural health clinics and federally qualified health centers using telehealth, including audio-only telephone calls, for the first time outside of the COVID-19 public health emergency (PHE), CMS noted.

The agency also finalized an extension for services added to Medicare's telehealth list during the COVID-19 PHE until CY 2023. The rule also extended inclusion of some cardiac and intensive cardiac rehabilitation codes on the telehealth list through the end of CY 2023.

The agency finalized a higher Medicare reimbursement rate for the administration of certain vaccines. The rule states that Medicare will pay $30 per dose for the administration of the influenza, pneumococcal and hepatitis B virus vaccines and will continue to pay $40 per dose for administration of the COVID-19 vaccines.

Also finalized in the new rule are new policies regarding split, or shared, evaluation and management (E/M) visits, implementation of new modifiers for physical and occupational therapy services furnished by physical therapist assistants and occupational therapy assistants, and authorization of the direct payment of physician assistants for qualifying services.

Healthcare industry groups are coming out against the reduced conversion factor in CY 2022.

The AMA reported that the reduction in the conversion factor is about 3.85% but that cut is on top of other looming Medicare physician reimbursement reductions, which could reach close to 10% of physician payments next year if Congress does not interview.

"Failing to prevent these cuts could result in significant challenges," said Jerry Penso, MD, MBA, president and CEO of the American Medical Group Association, which also conducted the survey asking providers what they would do if full physician reimbursement cuts were enacted.

2022 MIPS Final Rule – Key Takeaways

-- Staff, *MD Interactive*, November 5, 2021

On November 2, 2021, CMS issued the Final Rule for the 2022 Medicare Physician Fee Schedule which also included several changes to the Quality Payment Program (QPP).

The Rule makes significant revisions to the existing MIPS program and outlines a timeframe for transitioning to the new MIPS Value Pathways (MVPs). Here are the key takeaways that will have a major impact on the future of clinician reporting.

Key QPP policies in the 2022 performance year include:

- Revising the definition of MIPS eligible clinicians to include social workers and certified nurse-midwives.
- Setting the MIPS performance threshold at 75 points and exceptional performance threshold at 89 points. The 2022 performance year is the last year for an additional MIPS adjustment for exceptional performance.
- Weighting cost and quality performance categories equally (as statutorily required) at 30%
- Revising quality scoring policies, including introduction of a floor for new measures (7 points for first year, 5 points for second year) and removal of outcome/high priority measure bonus points and end-to-end electronic reporting bonus points
- The maximum payment adjustment for 2022 remains the same at +/- 9% and will be applied towards a clinician's 2024 Medicare Part B payments for covered professional services.

Quality Measures

There are 200 Quality measures available for the 2022 performance period. This includes substantive changes to 87 existing Quality measures, one new specialty measure set for certified nurse-midwives, four new Quality measures (including 1 new administrative claims measure), and removal of 15 existing Quality measures (two are applicable to Medicare Part B Claims only).

Cost Category

The Final Rule will add five newly developed episode-based Cost measures for the 2022 performance period.

Improvement Activities Category

CMS will update the Improvement Activities inventory for the 2022 performance year, including adding seven new activities and modifying 15 current activities. There are six activities that will be removed from the IA inventory.

The Final Rule will also allow CMS to suspend an Improvement Activity if there is a reason to believe that the continued collection raises possible patient safety concerns or is obsolete.

Promoting Interoperability (PI) Category

CMS will apply automatic reweighting of the PI category for the following clinicians, beginning with the 2022 performance period:

Clinical social workers
Small practices

Small Practices

The Final Rule updates the redistribution policies for small practices. When the Promoting Interoperability performance category is reweighted the following category weights will apply:

Quality will be weighted at 40%.
Cost will be weighted at 30%.
Improvement Activities will be weighted at 30%.

In cases where both the Cost and the Promoting Interoperability performance categories are reweighted, the Quality and Improvement Activities categories will be equally weighted at 50%.

The 2022 Final Rule makes significant changes to the traditional MIPS program next year and lays out a plan to introduce MVP reporting. MIPS eligible clinicians should begin reviewing these changes now so they understand the potential impact on their reporting practices.

DEA Guidance: Use of a Home Address

This guidance document addresses issues pertaining to individuals and mid-level practitioners using their home address as a principal place of business or professional practice and the home address becoming a controlled premise, subject to unannounced inspections and administrative warrants under existing DEA regulations.

To Whom It Applies: DEA-Registered Individuals and Mid-Level Practitioners

Question: Can an individual practitioner, to include a mid-level practitioner, use their home address as the principal place of business or professional practice

Answer: Yes. An individual practitioner is a physician, dentist, veterinarian, or other individual licensed, registered, or otherwise permitted, by the United States or the jurisdiction in which he/she practices, to dispense a controlled substance in the course of professional practice, but does not include a pharmacist, a pharmacy, or an institutional practitioner.

A mid-level practitioner means an individual practitioner, other than a physician, dentist, veterinarian, or podiatrist, who is licensed, registered, or otherwise permitted by the United States or the jurisdiction in which he/she practices, to dispense a controlled substance in the course of professional practice.

DEA regulations require a separate registration for each principal place of business or professional practice at one general physical location where controlled substances are manufactured, distributed, imported, exported, or dispensed by a person (21 CFR 1301.12(a)) DEA regulations do not prohibit individual and mid-level practitioners from using their home address.

If an individual practitioner or mid-level practitioner does choose to use their home address as a principal place of business or professional practice, the location becomes a "controlled premise" and is subject to unannounced inspections and administrative warrants under existing DEA regulations. They must also comply with the established recordkeeping and security requirements. (November 3, 2021 (Revised #1), Original Posted July 8, 2021 DEA website).

Health Choice Member ID Numbers are Changing January 1, 2022

All members received new ID cards in December 2021. The new format will look like this for each line of business:

Health Plan	ID #
Health Choice AZ	HCIA12345678
Health Choice Pathway	MZHHC12345678
Health Choice Pathway (Dual Members)	Medicare: MZHHC12345678 AHCCCS HCIA12345678

MIPS UPDATES

2021 MIPS Automatic Extreme and Uncontrollable Circumstances Update

CMS is automatically applying the MIPS extreme and uncontrollable circumstances (EUC) policy to ALL individual MIPS eligible clinicians for the 2021 performance year.

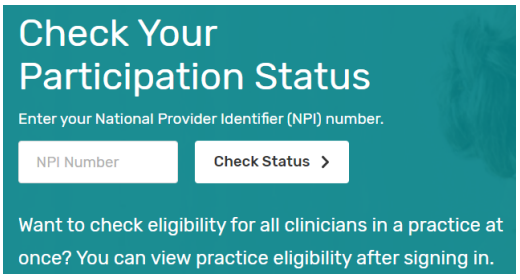
The automatic EUC policy only applies to MIPS eligible clinicians participating as individuals.

The automatic EUC policy does not apply to groups, virtual groups, or APM Entities.

Reminder: December 31, 2021, is the deadline to submit your Promoting Interoperability Hardship Exception and Extreme and Uncontrollable Circumstances (EUC) Applications for the 2021 performance year.

Check Your Initial 2022 MIPS Eligibility on the QPP Website

You can now use the Quality Payment Program Participation Status Tool to check your initial 2022 MIPS eligibility status. The tool can be found on the QPP website: https://qpp.cms.gov



Just enter your NPI number to find out whether you need to participate in MIPS during the 2022 performance year.

To be eligible to participate in MIPS in 2022, you must:

- Bill more than $90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS); **AND**
- Furnish covered professional services to more than 200 Medicare Part B beneficiaries; **AND**
- Provide more than 200 covered professional services under the PFS.

If you don't exceed all 3 of the above criteria for the 2022 performance year, you're excluded from MIPS. However,

you have the opportunity to opt-in to MIPS and receive a payment adjustment if you meet or exceed 1 or 2, but not all, of the low-volume threshold criteria.

Alternatively, you may choose to voluntarily report to MIPS and not receive a payment adjustment if you don't meet any of the low-volume threshold criteria or if you meet some, but not all, of the criteria.

Please note, CMS now evaluates the low-volume threshold for MIPS Alternative Payment Model (APM) participants at the individual or group level, just as it does for participants who aren't in MIPS APMs. CMS no longer evaluates APM Entities for eligibility against the low-volume threshold.

Note: The QPP Participation Status Tool will be updated with clinicians' QP status 3 times during the performance year.

Questions?
Please contact the Quality Payment Program at 1-866-288-8292 (Monday-Friday 8 a.m.- 8 p.m. ET) or by e-mail at: QPP@cms.hhs.gov. To receive assistance more quickly, consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET.

Medicare News

Doctors and Clinicians: Don't forget to preview your performance information!

CMS opened the Doctors and Clinicians Preview Period on November 15, 2021. The Preview Period provides an opportunity for doctors and clinicians to review their 2020 Quality Payment Program performance information before it is publicly reported on clinician and group profile pages on Medicare Care Compare and in the Provider Data Catalog (PDC).

Providers can access the secured Preview through the QPP website at https://qpp.cms.gov.

For additional assistance with accessing the QPP website or obtaining your HARP user role, contact the QPP Service Center at: QPP@cms.hhs.gov.

Medicare Shared Savings Accountable Care Organizations (ACOs) and Next Generation Model ACOs can preview their performance information via their 2020 MIPS Performance Feedback Reports. Shared Savings Program ACOs can also review quality performance information on their previously provided 2020 Quality Performance Reports.

The Preview Period will close on December 14, 2021, at 8 p.m. ET (5 p.m. PT).

The Staff at DRS wishes you all a safe and happy holiday season!

We are working hard to keep you on the edge of healthcare. Help us fulfill our strong commitment to maintain our level of service excellence by providing us with your feedback. Please feel free to contact Sue or Julie at 1.877.845.2969.

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