Massachusetts Medical Society

Every physician matters, each patient counts.

New State and Federal Notice and Price Transparency Requirements

Introduction

Addressing the problem of out-of-network billing, or "surprise billing," has been a long-standing policy priority in Massachusetts. Recent state and federal actions, designed to protect patients by prohibiting surprise billing, require robust notice and price transparency disclosures. The Medical Society strongly supports a comprehensive approach to the issue of out-of-network billing that protects patients from surprise out-of-network bills and provides appropriate notice and price transparency to patients.

In December 2020, Congress passed the No Surprises Act (NSA), which became effective January 1, 2022, including in Massachusetts. As part of a multiagency, multipart rule-making process, interim final rules Part I and Part II were issued, covering the notice and consent provisions from the NSA, as well as good faith estimate requirements for uninsured and self-pay patients (among other issues). On January 1, 2021, Governor Baker signed *An Act Promoting a Resilient Health Care System That Puts Patients First* (the Patients First Act), Chapter 260 of the Acts of 2020, which contains notice and transparency requirements for both in-network and out-of-network providers. **Implementation and enforcement of penalties of the surprise billing notice and price transparency provisions in the Patients First Act have been statutorily delayed until July 31, 2022.** For more information on the Patients First Act, please visit here. In the meantime, the Medical Society will continue to work with the legislature to propose adjustments to the state notice and price transparency provisions to better align with analogous requirements under the NSA and in a way that prioritizes patients and minimizes unnecessary administrative burden on physicians.

These new, overlapping disclosure requirements on physicians related to notice and price transparency have created significant challenges for physicians seeking to comply in good faith with both laws. While the implementation of the state requirements has been delayed, some version of these requirements is likely to take effect on July 31, 2022. As such, this resource is intended to help physician practices prepare to understand whether and how both the state and federal disclosure requirements may apply for any given patient and to provide considerations for operationalizing these new requirements; it is not a comprehensive guide to all surprise billing provisions of the NSA. This practice guide contains a flowchart with prompts to help physicians and practice managers understand which sets of requirements may apply for a given patient. Additional information regarding the substance and timing of the state and federal disclosure requirements is outlined on pages 3–8.

ADDITIONAL FEDERAL REQUIREMENTS FOR PHYSICIANS

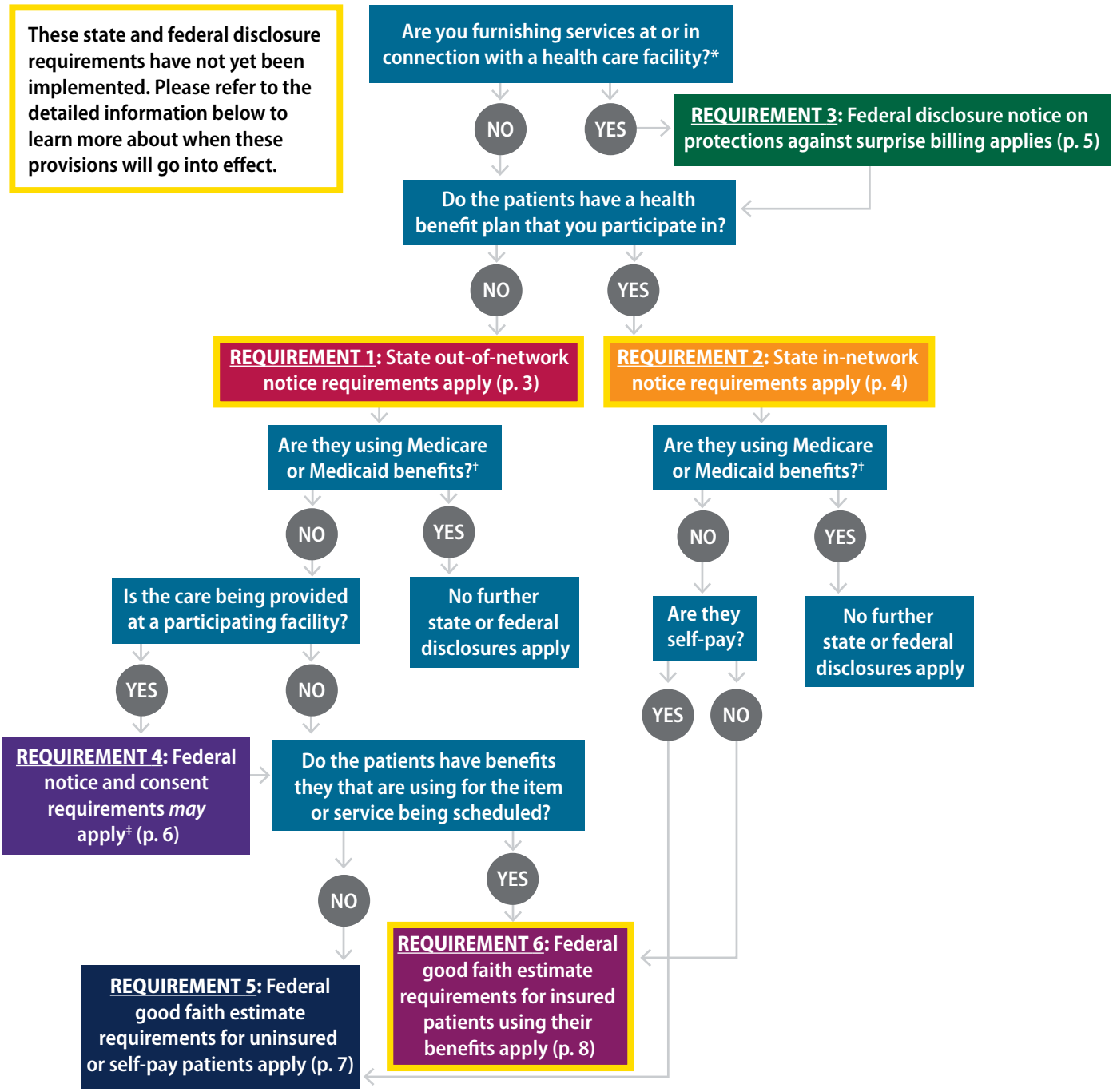
This guide is solely focused on requirements in Massachusetts and federal laws related to notice and price transparency. There are additional requirements physicians will need to meet under the federal *No Surprises Act*. Please view the MMS Surprise Billing and Patient Notice Resource Center for additional information and resources.

This information is intended to serve as a general resource and guide. It is not to be construed as legal advice. Attorneys with knowledge of the Massachusetts and federal surprise billing and price transparency laws should be consulted.

Flowchart for Notice and Consent Provisions

Related to State and Federal Surprise Billing Laws

This flowchart is intended to help physician practices understand what different state and federal notice and price transparency disclosure requirements may apply in any given patient scenario. The flowchart poses a series of yes or no questions; how you answer will indicate which notice and disclosure requirements apply. As you move through the chart, multiple sets of requirements may apply for a given patient depending on factors like the patient's insurance, your network status, and the practice setting. Notably, one set of state disclosures will always apply, and how you answer the questions overall will determine what, if any, federal disclosures may also apply. **Click on the requirement boxes below for more information.**



*See definition for health care facility and related exceptions under Requirement 3.
†Also applies to people with coverage through Indian Health Services, Veterans Affairs Health Care, or TRICARE.
‡Patients cannot waive federal balance billing protections by providing consent for certain types of care; see Requirement 4 for more information.

Massachusetts Notice and Price Transparency Disclosures

Requirement 1: State Notice Requirements for Out-of-Network Providers[1]

The following requirements will be implemented and enforced starting on July 31, 2022.[2]

- Providers who do not participate in a patient's or prospective patient's health benefit plan must notify the patient of their out-of-network status:[3]
  - Verbally and in writing at least seven days before the scheduled admission, procedure, or service if scheduled more than seven days in advance
  - Verbally at least two days before, and in writing at the time of arrival for, the scheduled admission, procedure, or service if scheduled within seven days of the admission, procedure, or service
- Additional disclosures for out-of-network providers required at the time of scheduling include the following:[4]
  - The charge amount and the amount of any facility fees for the admission, procedure, or service;
  - Information that the patient or prospective patient will be responsible for the provider's charge and applicable facility fees for the admission, procedure, or service that are not covered through the patient's health benefit plan; and
  - Information that the patient or prospective patient may be able to obtain the admission, procedure, or service at a lower cost from an in-network health care provider.

[1]The requirements of G.L. c. 111, s. 228 apply to health care providers as defined at G.L. c. 111, s. 1 and include doctors of medicine, osteopathy, and dental science; registered nurses; social workers; chiropractors; psychologists; interns, residents, fellows, or medical officers licensed per c. 112, s. 9; registered pharmacists; hospitals, clinics, or nursing homes; and public hospitals.

[2]The implementation and enforcement of these state requirements have been statutorily delayed, per sections 3 and 36 of Chapter 22 of the Acts of 2022, until July 31, 2022. The Department of Public Health is currently revising its guidance relative to these requirements. Please check back with the Department of Public Health for any future guidance.

[3]Chapter 111 s. 228(e)

[4]Chapter 111 s. 228(b)(3)

Requirement 2: State Notice Requirements for In-Network Providers

The following requirements will be implemented and enforced starting on July 31, 2022.[5]

- **Disclosures required at the time of scheduling[6] an admission, procedure, or service for a patient or prospective patient for a condition that is not an emergency medical condition[7] or upon request by an individual:[8]**
  - Disclose whether you are participating in the individual's health benefit plan;
  - Inform the individual that they may request disclosure of the allowed amount and facility fees for the scheduled item or service. If they request that information, you must provide it to them within two days of the request. If you are unable to provide specific allowed amount, you must give the estimated maximum allowed amount; and
  - Inform the individual that they may obtain more information regarding out-of-pocket costs through their carrier.
- **Referrals[9] and Direct Scheduling[10]**
  - If referring a patient to another provider, you must disclose the following:
    - Whether referred provider is in the same provider organization as you;
    - The possibility that the referred provider is out-of-network and if they are, then the patient may face additional costs, but the patient can verify the referred provider's network status before making an appointment or receiving the services from the referred provider; and
    - Sufficient information about the referred provider to allow the patient to gather information to determine network status, and applicable out-of-pocket costs for the services, of the referred provider.
  - If directly scheduling a patient with another provider, you must do the following:
    - Verify the referred provider's network status for the patient, if possible; and
    - Notify the patient if the referred provider is out-of-network or if their network status could not be verified.

[5]The implementation and enforcement of these state requirements have been statutorily delayed, per sections 3 and 36 of Chapter 22 of the Acts of 2022, until July 31, 2022. The Department of Public Health is currently revising its guidance relative to these requirements. Please check back with the Department of Public Health for any future guidance.

[6]If a patient schedules a series of admissions, procedures, or services as part of a continued course of treatment, the patient or prospective patient may waive the requirement to receive disclosure of the provider's network status for subsequent admissions, procedures, or services for that course of treatment, but if the health care provider's status as participating in the patient's health benefit plan changes during a continued course of treatment, the health care provider must inform the patient of this change in status. Notably, additional disclosures regarding the patient's ability to request an allowed amount and facility fees and the ability to obtain more information through their carrier cannot be waived for subsequent admissions, procedures, or services scheduled as part of a continuing course of treatment.

[7]As defined in M.G.L. chapter 176O, section 1, "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 section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B)."

[8]Chapter 111 s. 228(b)(2)

[9]Chapter 111 s. 228(c)

[10]Chapter 111 s. 228(d)

Federal Notice and Price Transparency Disclosures

Requirement 3: Federal Disclosure Notice on Patient Protections against Surprise Billing

The following requirements are effective January 1, 2022.

- **Providers who furnish items or services at a health care facility or in connection with visits to a health care facility,[11] which is defined as a hospital, hospital outpatient department, critical access hospital, ambulatory surgical center, or independent freestanding emergency department, are required to do the following:[12]**
  - **Provide a disclosure notice** on patient protections against surprise billing.
    - The disclosure must include clear information regarding the following:
      - Restrictions on providers and facilities regarding balance billing in certain circumstances;
      - Any applicable state law protections against balance billing; and
        - For example, here is a description of existing Massachusetts protections: "Additional protections related to non-emergency services delivered by an out-of-network provider at an in-network facility also may be available to you under Massachusetts law depending on your insurance plan. If applicable, your providers must disclose whether they participate in your health benefit plan upon scheduling a service or at your request. If they do not participate in your network benefit plan, the provider must give you information on its charges, including any facility fees, and inform you that you may be able to obtain the services at a lower cost through an in-network provider. If a provider does not make these required disclosures to you in advance, the provider cannot balance bill you. These protections under Massachusetts law do not apply to you if you are enrolled in an employer self-funded health insurance plan."
      - Information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the prohibitions against balance billing.
        - Relevant state contacts to submit a complaint
          - The Massachusetts Attorney General's Office can be reached at (888) 830-6277.
          - Find more information about how to file a complaint with the relevant state board of licensure here.
        - Relevant federal contacts to submit a complaint
          - Visit the CMS website or contact the No Surprises Help Desk at (800) 985-3059.
          - For more information, visit www.cms.gov/nosurprises.
    - Though not required to use it, a model disclosure can be found here.
    - Disclosure should be publicly displayed on the website on a searchable home page and in a prominent spot in the office where individuals schedule care, check in for appointments, or pay bills.
    - The notice must be provided individually to commercially insured patients, including those in the Federal Employees Health Benefits Program (FEHBP),[13] no later than the time a bill is sent to the patient or a claim for payment is submitted to a health plan. The disclosure notice should also be provided directly to the patient in person, by mail, or via email, as selected by the individual.[14]
    - The disclosure notice must be limited to one page (double-sided) and must use a font size of 12 points or larger.

[11]Federal regulators (when implementing the law) included exceptions that narrow the providers responsible for furnishing this information: 1. Health care providers are not required to make the disclosures required under this section if they do not furnish items or services at a health care facility, or in connection with visits at health care facilities; and 2. Health care providers are required to provide the required disclosure only to individuals to whom they furnish items or services, and then only if such items or services are furnished at a health care facility, or in connection with a visit at a health care facility.

[12]These requirements apply to health care providers and health care facilities (including independent freestanding emergency departments). Health care facility is defined as follows: 1. A hospital (as defined in section 1861(e) of the Social Security Act), 2. A hospital outpatient department, 3. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act), and 4. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act. Independent freestanding emergency department means a health care facility (not limited to those described in the definition of health care facility with respect to non-emergency services) that 1. Is geographically separate and distinct and licensed separately from a hospital under applicable State law, and 2. Provides any emergency services as described in § 149.110(c)(2)(i).

[13]Under section 2799B-3 of the PHS Act, disclosure is required only to individuals who are participants, beneficiaries, or enrollees of a group health plan or group or individual health insurance coverage offered by a health insurance issuer — this also includes Federal Employees Health Benefits (FEHB) plans. The disclosure requirement is not required with respect to other individuals seeking care from a provider or facility.

[14]To the extent a provider furnishes an item or service covered under the plan or coverage at a health care facility (defined above), the provider satisfies the disclosure requirements (for posting the information at the facility or providing it directly to the patient) if the facility agrees to provide the information, in the required form and manner, pursuant to a written agreement between the provider and facility. However, the provider is still required to post the information on their website.

Requirement 4: Federal Notice and Consent

The following requirements are effective January 1, 2022.

- Nonparticipating providers furnishing non-emergency services at a participating facility[15] are required to do the following:
  - **Provide notice and obtain consent under limited circumstances:** Nonparticipating providers at in-network facilities providing scheduled services may not balance bill patients for services rendered *unless notice and consent was given*. Only under limited circumstances may a patient waive their balance billing protections for services given by out-of-network providers at in-network facilities.
    - **Consent cannot be obtained for the following:**
      - Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
      - Items and services provided by assistant surgeons, hospitalists and intensivists;
      - Diagnostic services, including radiology and laboratory services;
      - Other items and services provided by a nonparticipating or out-of-network provider if there is no participating or in-network provider who can furnish such items or services at such facility; and
      - 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 previous notice and consent obtained.
    - **Notice must include the following:**
      - Notification that the provider is an out-of-network provider;
      - A good faith estimate of charges;
      - A list of any participating or in-network providers at the facility who are able to provide the items and services and that the patient may be referred to the participating or in-network provider at the patient's option;
      - Information about whether prior authorization or other limitations may be required in advance; and
      - Clear statement that consent to receive the items and services is optional and the patient may seek care from a participating provider/facility at the in-network cost-sharing amount.
    - A standardized notice and consent patient form is provided here.
    - Timeframe within which notice and consent must be furnished:
      - If the service is scheduled more than 72 hours in advance, notice must be provided at least 72 hours before the date of the scheduled service.
      - If the service is scheduled within 72 hours, notice must be provided on the day the service is scheduled.
      - If the service is scheduled same day, notice must be given at least three hours prior to the service.
    - The provider must furnish the notice and consent in any of the 15 most commonly spoken languages in the provider's region and must provide an interpreter if the patient speaks a different language.
    - When billing a patient directly, the provider must include a copy of the signed consent with the bill.[16]
    - Notice and Consent documents must be retained for seven years.

[15]This is defined as a nonparticipating provider or nonparticipating emergency facility when furnishing certain post-stabilization services, or a nonparticipating provider (or facility on behalf of the provider) when furnishing non-emergency services (other than ancillary services) at certain participating health care facilities.
[16]When submitting a claim to a health plan, the out-of-network provider must indicate that the service was rendered during a visit to an in-network facility and, if applicable, provide a copy of the signed consent to bill at the out-of-network rate.

Requirement 5: Federal Good Faith Estimate for Uninsured or Self-Pay Patients

The following requirements are effective January 1, 2022.

- The following disclosure requirements apply to physicians regardless of practice setting:[17]
  - **Provide a disclosure notice** on patients' right to a good faith estimate (GFE) and the patient-provider dispute resolution process.
    - Health care providers are required to inform individuals who are not enrolled in a plan or coverage or a federal health care program (uninsured), or not seeking to file a claim with their plan or coverage (self-pay), both orally and in writing of their ability, upon request or at the time of scheduling health care items and services, to receive a GFE of expected charges.
    - A model notice and guidance can be found here.
    - Information regarding the availability of a GFE must be prominently displayed on the provider's and facility's website and in the office and on-site where scheduling or questions about the cost of health care occur.
  - **Provide GFE to *uninsured and self-pay* patients**[18] in advance of scheduled services, or upon request, for all items and services. Notably, any discussion or inquiry with uninsured or self-pay patients regarding the potential cost of items or services under consideration should be treated as a request for a GFE.
    - A standardized good faith estimate patient form is available here, along with additional information on what to include as part of the GFE.
    - The GFE can be provided electronically if a patient requests but must be delivered in a way that the patient can save and print, and it must be provided in clear and understandable language.
    - A convening provider (the primary provider scheduling the item or service) is responsible for providing the GFE to the patient and is required to receive cost estimates from co-providers (additional providers involved in that item or service). Patients may reach out directly to co-providers for cost estimates, at which point that provider would be required to provide a GFE to the patient.
    - A GFE must be furnished within the following timeframes:
      - Information for the GFE submitted by co-providers/facilities must be *received* by the convening provider no later than one business day after the co-provider or co-facility receives the request.[19]
      - A convening provider or facility must provide a GFE to an uninsured (or self-pay) patient within one of the following:
        - Three business days for a requested GFE or for scheduled care that is to be provided in at least 10 business days
        - One business day of scheduling care to be provided in three business days
      - When a GFE is provided initially in response to a request and then the item or service is subsequently scheduled, a new GFE must be provided to the uninsured (or self-pay) individual under the established timelines.
    - Note that a patient may initiate a patient-provider dispute resolution process for charges substantially in excess of the GFE (defined as over $400).

[17]For this portion of the rule, federal regulators define health care provider broadly: "a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, including a provider of air ambulance services." The Requirements Related to Surprise Billing, Part II Interim Final Rule (page 115; available here) also makes clear that this applies to items or services related to dental health, vision, substance use disorders, and mental health.

[18]Uninsured or self-pay patients include those who do not have benefits for an item or service or who do not seek to use their benefits for an item or service. The federal government has delayed implementation of the requirement that health care providers generate a GFE of charges for scheduled services for insured patients (to be provided to health plans for them to generate an advanced explanation of benefits), until the government issues regulations on this topic.

[19]Through December 2022, federal regulators will exercise enforcement discretion in situations where convening providers are not able to obtain information from relevant co-providers and co-facilities in the GFEs.

Requirement 6: Federal Good Faith Estimate for Insured Patients Using Their Health Care Benefits

***Some* of the following requirements are currently effective January 1, 2022.**

- **In effect:** Provide a disclosure notice on patients' right to receive a good faith estimate (GFE) and information regarding the patient-provider dispute resolution process. The disclosure is specifically related to a GFE for uninsured/self-pay patients (as stated under Requirement 5 on page 7), but health care providers need to display the disclosure notice (on their website and in the office) regardless of the patient's insurance status. A model notice and guidance can be found here.

- ***Not currently in effect: federal regulators have delayed implementation of this requirement until the government issues regulations on this topic (date TBD). While this requirement is written in statute, the requirements and timeline could change when this rule is implemented.***

  - For ***insured*** patients electing to use their health benefit plan, providers will be required to furnish a good faith estimate of expected charges (including any expected ancillary services) along with expected billing and diagnostic codes to the insurance carrier, who will then generate an advanced explanation of benefits provided to the patient within one of the following:

    - One business day after scheduling an item or service scheduled at least three business days in advance
    - Three business days after scheduling an item or service scheduled at least 10 business days in advance or after request by the patient

This information is intended to serve as a general resource and guide. It is not to be construed as legal advice. Attorneys with knowledge of the Massachusetts and federal surprise billing and price transparency laws should be consulted.

Massachusetts
Medical Society

860 Winter Street
Waltham, MA 02451-1411