COSMOS
Navigate the Compliance Universe

Compliance Today - March 2022
Ironically, No Surprises Act catches providers and facilities off guard

By Emily Cook, Esq.; Jamie B. Gelfman, Esq., CHC; and Drew McCormick, Esq.

Emily Cook (ecook@mwe.com) is Partner at the Los Angeles office, **Jamie B. Gelfman** (jgelfman@mwe.com) is Partner at the Miami office, and **Drew McCormick** (dmccormick@mwe.com) is Partner at the Boston office of McDermott Will & Emery LLP.

- linkedin.com/in/emily-cook-6354b616/
- linkedin.com/in/jamie-gelfman-20b60b56/
- linkedin.com/in/drew-elizabeth-mccormick-2756bb39/

Emily Cook

Jamie B. Gelfman

Drew McCormick

On December 27, 2020, the Consolidated Appropriations Act, 2021 was signed into law, which, among other provisions, included the No Surprises Act.[1] In July and October 2021, respectively, the Department of Health & Human Services, the Department of Labor, the Department of the Treasury, and the Office of Personnel Management (departments) issued two interim final rules implementing core aspects of the No Surprises Act (collectively, the NSA), including, but not limited to, prohibiting nonparticipating providers from balance billing individuals who receive services in participating facilities unless prior notice and consent is provided and obtained,[2] and requiring providers and facilities to provide good faith estimates (GFEs) to uninsured (or self-pay) individuals of expected charges prior to their scheduled services.[3]

As detailed below, these requirements (among the other NSA provisions) have resulted in providers and facilities scrambling to understand the complexities and nuances of the NSA, particularly as they apply to unique types of providers and facilities.[4] The NSA has also caused operational confusion as providers and facilities struggle to determine how to implement new processes to comply with the requirements, the majority of which became effective January 1, 2022, and the remainder of which become effective January 1, 2023. This has led to tremendous taxes on provider resources, and in some cases, has even resulted in litigation being filed to enjoin implementation of certain provisions of the regulations implementing the NSA.

NSA balance billing requirements cause confusion for certain types of providers and facilities

The NSA provides that if a participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer (collectively, an "insured person," or IP) receives emergency services at an emergency department of a hospital or at an independent freestanding emergency department, a nonparticipating provider or a nonparticipating emergency facility may not balance bill the IP for any amount in excess of their in-network cost-sharing amount.[5] The NSA similarly provides that if an IP receives nonemergency services from a nonparticipating provider in connection with a visit at a

participating facility, a nonparticipating provider may not balance bill the IP in excess of the their in-network cost-sharing amount, *unless* the nonparticipating provider provides the IP with notice of their rights under the NSA and obtains the IP's consent to waive the balance billing protections in advance of the service (notice and consent).

The NSA also requires all facilities, and all providers that provide services to IPs either in a facility or as part of a visit to a facility, to physically post (in the physical location and on the website) a one-page disclosure notice advising IPs of their balance billing protections, which must also be handed to IPs no later than the date and time on which the provider or facility requests payment from them (the disclosure notice).[6] This disclosure notice must be provided to IPs in addition to any notice and consent to balance bill, which is required only if that a nonparticipating provider seeks to do so.

These requirements have caused considerable confusion for providers and facilities as they seek to determine if and when these requirements apply to them and how to implement them by January 1. One common question is, "If we never balance bill patients, do we have to do anything to comply with the NSA?" The simple answer is, yes. Providers and facilities that never balance bill are still obligated to post and provide the disclosure notice, as described above (as well as a separate disclosure related to a self-pay or uninsured individual's right to obtain a GFE, as described in greater detail below). These requirements are part of the policy aims of the law related to transparency, as opposed to strictly protections against balance billing. These obligations apply very broadly and to providers that may believe they are outside of the reaches of the NSA.

What is a 'visit'?

Private physician groups have questioned whether the NSA, particularly the disclosure notice and notice and consent requirements, applies to them if they do not furnish services in a facility-type setting. However, the NSA applies to the provision of nonemergency services furnished by a nonparticipating provider *in connection* with a "visit" to a facility. A visit is defined broadly to include services furnished by a provider outside of the facility setting, including preoperative and postoperative services and telemedicine services.[7] For example, if a telemedicine provider anticipates providing nonemergency services to IPs as part of a visit to a facility where the facility is in network and the telemedicine provider is out of network, the telemedicine provider would be subject to the disclosure notice requirement (and the notice and consent requirement, should the telemedicine provider seek to balance bill). Due to the extremely broad nature of the NSA, it appears that most physician groups will be required, at a minimum, to post the disclosure notice, even if they do not intend to balance bill.

Providers have also raised questions about how often the disclosure notice must be provided. As noted above, such disclosures must be provided in connection with a visit to a facility, the definition of which is broad and does not include any exception or waiver process for instances in which an IP receives a series of treatments as part of a single course of treatment over a short period of time (e.g., daily radiation therapy treatments based on a cancer diagnosis). Therefore, based on a plain-language reading of the requirements under the NSA, a provider or facility may find itself in the position of providing multiple copies of a disclosure notice to the same patient within a short window of time, which may cause confusion and frustration.

When can a nonparticipating provider balance bill?

The NSA prohibits balance billing for nonemergency services furnished by nonparticipating providers in in-network facilities unless notice and consent is provided and obtained. However, the notice and consent exception is not available for certain "ancillary" services, including pathology, radiology, anesthesiology, neonatology, and laboratory services, and thus IPs who receive such services from nonparticipating providers cannot be balance

billed.[8] This exception to the notice and consent exception of the NSA has also raised a significant amount of questions for providers, who struggle to understand exactly what types of services fall within these broad categories. As a result, the departments have sought additional comments from stakeholders to clarify what services should constitute an ancillary service for purposes of this balance billing prohibition.

GFE and patient-provider dispute process, generally

The NSA requires "convening providers and facilities" to furnish a GFE of expected charges to uninsured (or self-pay) individuals, including individuals with health insurance plans who do not seek to file a claim with such plans, upon request or upon scheduling an item or service.[9] Convening providers and facilities, defined as the provider or facility who receives the initial request for a GFE from an uninsured (or self-pay) individual and who would be responsible for scheduling the primary item or service, are required to provide the GFE no later than one business day after the date of scheduling when a primary item or service is scheduled at least three business days before the date of service.[10] If a convening provider or facility receives a request for a GFE from an individual who does not have a scheduled appointment, the GFE must be provided within three business days of the request.

Among other requirements, the GFE must include an itemized list of items or services for the period of care, grouped by each provider or facility, reasonably expected to be provided for the primary item or service, and the expected charges associated with each item or service.[11] The NSA also places the burden upon convening providers and facilities to ensure that the GFE includes pricing information from "co-providers or co-facilities," defined as other providers or facilities reasonably expected to furnish items or services in conjunction with and in support of the primary item or service.

Significantly, the NSA establishes a patient-provider dispute resolution process, which may be initiated by an uninsured (or self-pay) individual if, after being furnished an item or service for which they received a GFE, the ultimate amount of billed charges by the provider or facility were "substantially in excess" of the GFE, defined as an amount that is at least $400 more than total amount of expected charges for the provider or facility listed on the GFE.[12]

GFE requirement presents unique challenges for certain providers and facilities

The GFE requirement has resulted in significant operational confusion for providers and facilities, who struggle to determine how to comply with not only the time frame requirements to prepare a GFE, but also with determining how to precisely estimate the total expected charges in light of the $400 dispute resolution threshold.

The NSA contains a detailed list of content requirements that a convening provider or facility must ensure is accurately incorporated into the GFE, including, but not limited to, an itemized list of items or services expected to be provided for the primary item or service; applicable diagnosis codes, expected services codes, and expected charges associated with each listed item or service; the name, National Provider Identifier, and Taxpayer Identification Number of each provider or facility represented in the GFE; and a list of items or services that the convening provider or facility 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.[13] Depending on when an uninsured (or self-pay) patient schedules an appointment or requests a GFE, the provider or facility has anywhere from one to three business days to compile this information and ensure it is accurate to avoid the patient-provider dispute resolution process.

For convening providers and facilities who provide specialized care, it may be difficult, if not impossible, to accurately anticipate and estimate all items and services to be provided as part of the primary item or service, to identify the applicable diagnosis codes, and to determine the expected charges associated with such items or services, particularly within a $400 error rate. For instance, certain providers, such as oncologists, often perform exploratory procedures, where the provider may not know in advance of the procedure exactly what the diagnosis is and what may be discovered during the procedure that may require the provider to perform an immediate, simultaneous procedure (such as removing a tumor or performing a biopsy). This may result in longer hospital stays and additional pharmaceutical costs for patients that were not initially incorporated in the GFE. This presents additional, unique challenges for facilities, particularly those that charge per diem rates for in-patient admissions and are unable to anticipate how many days a patient may be admitted in advance of an exploratory procedure.

The NSA provides that the GFE is not intended to include unanticipated, unforeseen items or services that are not reasonably expected as part of the primary item or service.[14] However, in the context of an exploratory procedure, although certain items or services may be unanticipated or unforeseen, they would not necessarily fall into this exemption from the GFE to the extent they are reasonably expected based on the scope of the specialty care or the exploratory procedure. Instead, the NSA provides that if a patient initiates the patient-provider dispute resolution process, a provider has the right to present evidence demonstrating that the underlying circumstances changed during the course of treatment that reasonably resulted in higher-than-expected charges. As such, providers are not afforded any flexibility or latitude with respect to preparing the GFE in the first place, which may result in providers having to partake in the dispute resolution process and defending the medical necessity of the items and services ultimately provided as part of the primary item or service. Providers and facilities, attempting to avoid the patient-provider dispute process, have an inherent incentive to overinflate the estimated charges on the GFE, which may result in deterring patients from proceeding with the treatment in the first place, a possibility that the departments acknowledge.

In addition to preparing precisely accurate and timely GFEs, convening providers and facilities are required to obtain pricing information from co-providers and co-facilities, whose expected charges reflected on the GFE are also separately subject to the patient-provider dispute resolution process. Convening providers and facilities are required to coordinate with co-providers and co-facilities within one business day of receiving a request for a GFE,[15] which requires both parties to develop and ensure that systems and processes are established to receive and provide the required information in an efficient and secure manner. The departments, acknowledging the operational challenges associated with convening providers and facilities having to obtain this information from co-providers and co-facilities by January 1, 2022, indicated that they would exercise enforcement discretion with respect to this requirement through December 31, 2022.[16] However, the NSA explicitly states that during this time period, convening providers and convening facilities are encouraged to include a range of expected charges for items or services reasonably expected to be provided and billed by co-providers and co-facilities. However, an uninsured (or self-pay) patient may directly request a GFE from a co-provider or co-facility, in which case the co-provider or co-facility would technically be considered a convening provider or facility and be required to provide a GFE (and would be subject to the $400 threshold for patient-provider dispute resolution process eligibility). As a result, all providers and facilities who accept uninsured (or self-pay) patients are theoretically in a position where they could be a convening provider or facility and be subject to these requirements.

Intersection of the NSA and state law

Another particularly challenging aspect of NSA implementation for providers is the intersection with state surprise billing laws. Under the Supremacy Clause of the U.S. Constitution, federal law preempts conflicting or inconsistent state law. The NSA provides that state laws are considered consistent with the NSA so long as they

do not prevent the application of the prohibition on balance billing or other federal requirements. As a result, state laws that are more protective than the NSA are not preempted, while state laws that are less protective than the NSA necessarily prevent the application of the requirements of the NSA that protect patients and are therefore preempted. Providers must analyze the requirements of any existing or new state surprise billing laws to determine whether the NSA preempts them. For example, some states (e.g., Massachusetts)[17] require disclosures to patients beyond those that are required by the NSA and are therefore not preempted. Other states expressly prohibit balance billing in even more circumstances than the NSA (e.g., Florida)[18] and are therefore not preempted. In these cases, providers must seek to comply with the requirements of the more protective state law, as well as the NSA.

Penalties and enforcement

With respect to facilities and providers, states have the primary enforcement authority under the NSA. However, the Centers for Medicare & Medicaid Services (CMS) has a statutory obligation to directly enforce any provision(s) of the NSA that a state fails to substantially enforce.[19] CMS previously issued a survey to states to determine, for each applicable provision and regulated entity, whether the state will enforce the requirements directly or through a collaborative enforcement agreement, or whether CMS will be responsible for enforcement.[20] The NSA allows for imposition of civil monetary penalties of up to $10,000 per violation. The penalty will be waived if a provider or facility did not knowingly violate, and should not have reasonably known that it violated, the NSA and reimburses any incorrect payments with interest.[21] The NSA statute also permits a hardship exemption to the imposition of civil monetary penalties (e.g., where the amount of the penalties may jeopardize the provider's ability to continue to provide services to the community). In September 2021, the departments issued a proposed rule addressing provider enforcement.[22] The proposed rule addresses, among other things, the factors that CMS would weigh in determining what penalties to impose, and when a provider or facility may request a hearing regarding the civil monetary penalty with an administrative law judge.

Conclusion

Now that the initial set of requirements under the NSA are effective, providers will need to continue to work through legal and operational questions regarding how best to implement and comply with its requirements. A number of questions remain, including, for example:

- How to coordinate responsibility for obtaining patient consent when out-of-network services are provided at an in-network facility?
- How to coordinate with co-providers and co-facilities for purposes of preparing the GFE for uninsured (and self-pay) patients (which will become a requirement as of January 1, 2023)?
- How to ensure GFEs are sufficiently accurate to avoid triggering the provider-patient dispute resolution process?

Additionally, a number of other aspects of the NSA are still under development, including, but not limited to, regulations that will dictate the process and requirements for providing GFEs to insured patients.

Takeaways

- The No Surprises Act (NSA) imposes a variety of obligations on facilities and providers that extend beyond simply restricting balance billing. In other words, just because a provider or facility does not plan to balance bill, does not mean that the NSA does not otherwise apply.

- Due to the extremely broad nature of the NSA, it appears that most physician groups will be required, at a minimum, to post the disclosure notice as described above.
- Several provisions of the NSA, including requirements to provide certain disclosures and good faith estimates, as well as to obtain consent under certain circumstances in order to be able to balance bill, became effective January 1. Providers who have not yet addressed these requirements should analyze their obligations as soon as possible and make efforts to comply.
- In addition to complying with the NSA, providers should consider the laws of the state(s) in which they are caring for patients to determine what additional requirements may apply.
- The NSA continues to evolve through additional rulemaking, as well as challenges being made against existing rulemaking. As such, facilities and providers should continue to track relevant updates and changes to ensure compliance.

1 Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, 134 Stat. 2757 (2020).
2 Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36,872 (July 13, 2021) .
3 Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980 (October 7, 2021) .
4 Note that this article does not address any of the NSA provisions pertaining to air ambulance providers.
5 Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36,904–905 .
6 Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36,912 .
7 Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36,882 .
8 Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36,910–911 .
9 Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 56,013–016 .
10 Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 56,016–017 .
11 Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 56,018–019 .
12 Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 56,024 .
13 Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 56,018 .
14 Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 56,037–038 .
15 Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 56,017 .
16 Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 56,023 .
17 Mass. Gen. Laws ch. 111, § 228.
18 Fla. Stat. §§ 627.64194, 641.513.
1942 U.S.C. §§ 300gg-22 ; 300gg-134.
20 For a current list of states for which CMS has issued letters detailing the provisions it will enforce versus the provisions the state will enforce, either directly or through a collaborative enforcement agreement, visit "Consolidated Appropriations Act, 2021 (CAA)," Centers for Medicare & Medicaid Services, accessed January 7, 2022, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA.
21 Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36,905 .
22 Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement, 86 Fed. Reg. 51,730 (September 16, 2021) .