NOTES

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The No Surprises Act Regulations

This newsletter is not legal advice, it is informational only. Any reader should consult an attorney for legal advice.

In 2021, Congress passed the Consolidated Appropriations Act of 2021, which included the No Surprises Act. The No Surprises Act imposed a range of new requirements on health care providers and insurance companies alike. The Act was generally intended to combat certain types of scenarios relating to surprise billings from out-of-network (OON) providers as well as bills to uninsured patients. For example, when an insured patient goes to the hospital for a surgery, and receives anesthesia services from an OON anesthesia provider, the patient could end up with a high bill, most of which the patient would have to pay out of pocket. The law, among other things, prohibited such practices for certain emergency services provided at in-network health care facilities, and similarly prohibited the practice for non-emergency services when provided at an in-network health care facility without the patient's consent. The law also imposed transparency requirements for health care providers and health plans, which apply to <u>all</u> providers. The balance billing prohibitions apply to out-of-network providers rendering services in facilities.

In broad strokes, the two IFRs address two general areas relevant to physician practices and associated entities: (1) balance billing prohibitions (addressed in the Part I IFR); and (2) transparency in billing requirements (addressed in the Part II IFR). While there is overlap between the two, the specific requirements for each are different and nuanced. Enforcement of these provisions will be a combined effort with states enforcing state law, and the federal government also being able to impose civil money penalties of up to $10,000 for violations, meaning that the No Surprises Act and these regulations impose real compliance concerns on providers. This <u>AGG Note</u> is not intended to explain every aspect of the regulations, but rather to clarify specific aspects of the two IFRs that most affect our clients.

<u>Transparency Rules: All In</u>

Separate from the balance billing prohibitions, the Part II IFR imposed upon <u>*all*</u> health care providers, *regardless of setting and even when not in connection with a facility visit*, a requirement to provide good faith estimates (GFEs) that inform the patient of the provider's expected charges to the patient, when the patient is (a) paying out of pocket, or (b) uninsured. Depending on whether the health care provider actually interacts with the patient and provides separate services, the provider may be a "convening provider" or a "co-provider."

A "convening provider" is a provider or health care facility that receives the initial

request from the patient for a GFE, and which is responsible for scheduling the primary item or service for the patient. In essence, the "convening provider" is the first point of contact in the health care system. A request for a GFE any discussion or inquiry regarding the potential costs of items/services.

A "co-health care provider" or "co-provider" is a provider or facility other than the convening provider that furnishes items or services customarily provided in conjunction with the primary item or service. As an example, the regulators describe a knee surgery wherein the GFE would need to include fees for the physicians, anesthesiologists, assistant surgeons, facility fees, prescription drug fees, and DME fees. Each of these services provided in association with the patient's visit for the surgery, and would not be separately scheduled by the patient, and therefore would each be co-providers. The implication, therefore, is that services which are separately scheduled by the patient treat each scheduling entity as a "convening provider," with primary responsibility to provide the initial service.

So, if a patient visits a primary care provider for a visit, that primary care provider is a "convening provider." If the primary care provider orders lab studies for the patient, the lab is likely also going to be a "convening provider," assuming the patient schedules their own lab services for themselves. The regulations themselves state that, if a patient separately schedules or requests a GFE from a provider that would otherwise be a co-provider, that provider is considered a convening provider.

Convening Provider Duties

When an uninsured or self-pay patient schedules an item or service, the convening provider has the following duties:

They must inquire as to whether the patient is enrolled in a health plan or federal health care program, and whether the patient intends to submit a claim for the primary item or service under that plan's coverage.

They must inform all uninsured/self-pay patients of the availability of a GFE when scheduling the item or service or upon the patient's request. This must be provided in written format in a clear and understandable manner, must be prominently displayed (and easily searchable from a public search engine) on the convening provider's website, in the office, and on-site where scheduling or questions about the cost of items/services occurs.

Upon request for a GFE, the provider must, within 1 business day of scheduling or the request, contact all co-providers who are reasonably expected to provide items/services in conjunction with and in support of the primary item or service to obtain GFEs from them. The request to the co-providers must include the date that the GFE must be received by the convening provider.

The convening provider must provide the GFE to the patient within varying timeframes, depending on how far in advance the item/service is scheduled. For an item/service scheduled at least 3 business days before it will be furnished, the GFE must be provided not later than 1 business day after the date of scheduling. For items/services scheduled at least 10 days in advance, the GFE must be provided within 3 business days of the date of scheduling. When the GFE is requested by an uninsured/self-pay individual, no later than 3 business days after the date of the request.

Co-Provider Duties

Co-providers must submit GFEs to convening providers within 1 business day of the convening provider's request. Co-providers also must notify and provide new GFEs to convening providers if the co-provider anticipates changes to the scope of the GFE information previously provided, and remain bound to the original GFE if such changes occur less than 1 business day before the item or service is scheduled to be provided. In other words, if the patient's service is scheduled at noon on May 5, and the co-provider discovers at 6pm on May 4 that its original GFE may change, it is still bound by the first GFE.

CMS has provided guidance which clarifies that, for the 2022 calendar year, it will exercise its enforcement discretion where a GFE provided to an uninsured or self-pay patient does not include expected charges from co-providers, although the regulators note that co-providers may certainly provide GFEs prior to December 31, 2022. As a practical matter, where possible, convening providers should still try to obtain such information, and co-providers should get in the habit of providing this information upon request where possible.

Balance Billing Prohibitions

The No Surprises Act sought to curtail the practice of "balance billing" when an OON provider demands payment from the patient beyond their normal cost-sharing obligations (co-payments and deductibles) and above what the patient's insurer pays for a given service when rendered in-network. Most payors prohibit in-network providers from engaging in this practice through their participation agreements. In Medicare and Medicaid, the practice is already prohibited by law.

For Emergency Services

The Part I IFR put in place regulations, applicable on January 1, 2022, that apply to emergency, non-emergency, and ancillary services rendered by non-participating providers in a participating health care facility. The regulations define "health care facility" to mean a hospital, hospital outpatient department, critical access hospital, or ambulatory surgical center. A "nonparticipating provider" is defined to include any physician or other health care provider who does not have a contract directly or indirectly with a health insurer – in other words, anyone providing services OON.

For emergency services, non-participating providers are prohibited from billing and holding patients liable for payments for emergency services provided to the patient when the bill exceeds the patient's cost-sharing requirements. The term "emergency services" is defined to mean an appropriate medical screening examination within the capability of the ED of a hospital, including ancillary services routinely available to the ED, as well as further examination and treatment required to stabilize the patient. The term also includes the items and services furnished by non-participating providers after the patient has been stabilized and as part of outpatient observation or inpatient or outpatient stay for the emergency visit.

Such additional services furnished by non-participating providers do *not* constitute "emergency services" when appropriate notice has been provided and consent obtained, provided additional conditions are met, such as: the attending physician determines the patient can travel to another facility; the patient is in condition to receive the notice and consent as determined by the attending physician; and the patient is in a condition to provide informed consent in

accordance with applicable state law.

For Non-Emergency Services

Non-emergency services (including post-stabilization services), the balance billing prohibitions generally prohibit non-participating providers from billing patients for amounts that exceed the patient's cost-sharing requirement (i.e., co-payments or deductibles) when the services are provided at a participating health care facility or "in connection with" a visit to a participating health care facility. However, the prohibitions will *not* apply if the health care provider provides the patient with (1) notice, and (2) obtains the patient's consent to balance bill the patient.
The form of notice and consent that must be provided to the patient to waive the balance billing prohibitions is also outlined in the regulations. Fortunately, CMS has published sample language that may be used, which can be found on their website. (https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets). CMS has also published on its website general guidance including some frequently asked questions, which can be found at the same page.

Ancillary Services

Providers of "ancillary services" cannot take advantage of these exceptions. Such services are defined to mean items and services related to emergency medicine, anesthesiology, pathology, radiology and neonatology; services of assistant surgeons, hospitalists, and intensivists; diagnostic services (e.g., radiology and laboratory services); and items and services provided by a non-participating provider when there is no participating provider who can furnish the item or service at the facility. For these types of providers, the balance billing prohibitions cannot be waived and will always apply; they cannot avail themselves of the notice and consent exception.

Who Is Not Affected

It is worth unpacking the health care providers to which the balance billing prohibitions do *not* apply. First, they do not apply to health care providers who are in-network. Second, the prohibitions do not apply to providers who do not provide services in a facility setting, or in connection with a visit to a health care facility. Where things become more complicated is in determining which providers provide services "in connection with" services provided in a facility setting.

Today, the regulations do not define the phrase "in connection with." As a result, health care providers are left to analyze what would constitute a service rendered "in connection with" a hospital service. The regulations are not explicit about how close the "connection" must be to fall within their scope. Thus, it remains unclear whether, for example physical therapy or other rehabilitation services provided after a surgery would be considered "in connection with" the visit occasioning the surgery itself. The safer course is to provide the required notice and attempt to secure the patient's consent if the provider is concerned that their service may be seen as "in connection with" the visit.

Conclusion

The details on the transparency rule, including timing concerns, are extensive. The balance billing prohibitions create their own new compliance challenges. All providers will need to grapple with the transparency requirements and determine whether and when they are a convening provider or co-

provider.

While enforcement of the transparency requirements for co-providers may be delayed, convening and co-providers alike ought to prepare now for 2023 when CMS may no longer choose to waive its enforcement authority. The sooner providers become comfortable with these new rules, the better.

It is worth noting that the rules are still *interim* final rules, meaning that the regulators have not yet responded to commentary, and may yet provide both additional guidance and rule changes. We will continue to follow these changes to better assist our clients.