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Convening and Co-Provider Responsibilities under the No Surprises Act

Authors: Mary Grace Griffin, Allison M. Cohen
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The No Surprises Act (NSA), which took effect on January 1, 2022, includes protections from surprise bills for patients who are uninsured or covered under group or individual plans. It will be necessary for both facilities and hospital-based providers to take action to comply with new obligations arising out of the NSA.

NSA protections apply to most emergency care and to non-emergency services provided by out-of-network providers at in-network facilities. Under the NSA, covered providers are prohibited from billing patients more than the amount they would have paid if they received these services in-network. Moreover, out-of-network providers and facilities cannot "balance" bill the patients an amount greater than the in-network cost-sharing requirement for these services unless the patient consents to waive balanced billing protections in certain permitted circumstances.

Good Faith Estimates (GFEs) for Uninsured or Self-Pay Patients

Under the NSA, uninsured patients and self-pay patients are entitled to a GFE of expected charges from providers before scheduled services or upon request as long as the service is scheduled at least three days in advance. No specific specialties, facility types, or sites of service are exempt from the requirement to provide a GFE.

An "uninsured individual" is one who is not enrolled in a group health plan, or group or individual health insurance coverage, or a federal health care program, or a Federal Employees Health Benefits (FEHB) program health benefits plan. A patient covered only by short-term limited-duration insurance is considered uninsured for this purpose and is entitled to receive a GFE. A "self-pay individual" is one who is enrolled in but is not seeking to have a claim submitted to their group health plan, health insurance coverage, or FEHB program health benefits plan for the item or service being scheduled or for which a GFE is requested. Under the NSA, providers and facilities are generally not required to provide GFEs to patients insured under Medicare, Medicaid, or other federal health care programs. If the actual charges by an individual provider or facility exceed the GFE amount by more than $400, the patient is entitled to use a dispute resolution process to have an independent third party review the case and determine appropriate payment.

Physicians' responsibilities for the GFE differ depending on whether they serve as a "convening provider" or a "co-healthcare provider." A convening health care provider or facility is the provider or facility that is responsible for scheduling the primary items or services or that receives an initial request for a GFE. Other providers or facilities that furnish items or services in conjunction with the primary item or service furnished by the convening provider or facility are considered co-providers and co-facilities.

Convening Provider Responsibilities

At the time of scheduling, a convening provider must inquire whether a patient is covered under commercial health coverage, Medicare, Medicaid or FEHBP and, if so, whether he or she intends to use that coverage. The convening provider is then required to inform uninsured and self-pay patients of the availability of the GFE. When inquiring about whether a patient is enrolled in a plan or coverage, providers may wish to consider discussing with the patient whether there are situations where the patient expects that the plan or coverage

may not provide coverage for certain items or services. Doing so would allow the provider to better determine whether the patient is self-pay, requiring a GFE.

In addition, notice of the availability of the GFE must be posted on the provider's website, at the office, and on-site where scheduling or cost questions arise. The notice must be clear, understandable, prominently displayed and easily searchable.

A patient may request a GFE prior to scheduling care. Convening providers must treat any discussion with or inquiry from an uninsured or self-pay patient regarding costs to be a request for a GFE. Regardless of whether a patient formally or informally requests a GFE, the convening provider or facility is required to provide a GFE when a service or item is scheduled.

No later than one business day after scheduling the primary item or service or receiving a request for a GFE, the convening provider or facility must request estimates from each co-provider or co-facility expected to provide services or items in connection with the convening provider's or facility's services or items. When a service or item has been scheduled, the GFE is to be provided not later than one business day after the date of scheduling if the service or item is scheduled between three and nine business days before the service or item. The GFE is to be provided within three business days of scheduling if the service or item is scheduled at least ten business days in advance. If a GFE is requested before the service or item is scheduled, the GFE is due within three business days. Once the service or item is scheduled, a new GFE must be provided. When a service or item is scheduled less than three business days before it is furnished, the convening provider is not required to deliver a GFE.

The GFE must be provided in written form either on paper or electronically (for example, electronic transmission of the GFE through the convening provider's patient portal or electronic mail), pursuant to the uninsured or self-pay patient's requested method of delivery. GFEs provided to uninsured or self-pay patients that are transmitted electronically must be provided in a manner that the uninsured or self-pay patient can both save and print and must be provided and written using clear and understandable language and, in a manner calculated to be understood by the average uninsured or self-pay patient. If a patient requests that the GFE information is provided in a format that is not paper or electronic delivery, such as orally over the phone or in person, the provider/facility may provide the GFE information orally but must follow-up with a written paper or electronic copy.

The GFE must include expected charges for the items or services that are reasonably expected to be provided in conjunction with the primary item or service, including items or services that may be provided by other providers and facilities. The convening provider is responsible for collecting GFE estimate amounts from all co-health care providers who are expected to provide care in conjunction with the item or service that is scheduled with the convening provider. The written GFE requires the following components:

- Patient name and date of birth,
- Clear description of service and date scheduled (if applicable),
- List of all items and services (including those to be provided by co-providers),
- Current Procedural Terminology (CPT) code, diagnosis code, and charge per item of service,
- Name, National Provider Identifier, and Taxpayer Identification Number of all service providers and the state where the services will be rendered,

- List of items from other providers that will require separate scheduling,
- Disclaimer that separate GFEs will be issued upon request for services that require separate scheduling and that CPT codes, diagnosis codes, and charges per item of service will be provided in those separate GFEs,
- Disclaimer that there may be other services required that must be scheduled separately during the course of treatment and are not included in the GFE,
- Disclaimer that this is only an estimate, and that actual services and charges may differ,
- Disclaimer informing the patient of their rights to a patient-provider dispute resolution process if actual billed charges are substantially above the estimate, as well as where to find information on how to start the dispute process,
- Disclaimer that the GFE is not a contract, and the patient is not required to obtain services from the provider.

A GFE is required even if there is a set price for the service. For recurring services, a provider may provide a single GFE, as long as the GFE is updated at least every 12 months. Providers and facilities are encouraged to review any previously issued GFE related to the primary item or service and make all applicable changes when providing the new GFE. Providers and facilities are also encouraged to communicate these changes upon delivery of the new GFE to help patients understand what has changed between the initial GFE and the new GFE.

Co-Provider Responsibilities

Co-providers (and co-facilities) must provide the GFE information within one business day of a request from a convening provider or facility. Co-providers and co-facilities must update their estimate if they anticipate any changes to the scope of services after they submit their update (e.g., anticipated changes to the expected charges, items, services, frequency, recurrences, duration, providers, or facilities). If the co-provider or co-facility changes less than one business day before the service is scheduled to be furnished, the replacement co-provider or co-facility must accept the estimate of expected charges that had been previously provided. If providers or facilities discover an error in the GFE before the service is rendered, the provider or facility must correct the error as soon as practicable after discovery.

Each co-provider or co-facility is required to provide to the convening provider or facility:

1. The patient's name and date of birth,
2. An itemized list of items and services to be provided by co-provider or co-facility, with diagnosis and procedure codes as well as expected charges,
3. The name of and identifying information for each provider or facility,
4. A disclaimer that the estimate is not a contract.

If an uninsured or self-pay patient directly contacts a provider to schedule a service or request an estimate and that provider would otherwise have been considered a co-provider, the provider is treated as a convening provider for the purpose of the GFE rules. Under these circumstances, the provider must meet all requirements of convening providers and facilities for issuing a GFE to an uninsured or self-pay patient.

The GFE must be preserved as part of the patient's medical record for at least six years, and a copy must be provided to the patient upon request during that period.

Dispute Resolution of Patient Charges

An uninsured or self-pay patient may dispute any bill that exceeds by more than $400 the amount listed for the provider or facility in the GFE. A patient may initiate the dispute resolution process by submitting an "initiation notice" to HHS. HHS refers the notice to the state, if the state has adopted its own patient-provider dispute resolution process. The dispute resolution entity will notify the provider or facility if it determines the dispute is eligible for dispute resolution (for example, the difference between the GFE amount and the billed amount exceeds $400).

Once notified that the dispute resolution process has been initiated, the provider or facility has ten business days to provide a copy of the disputed GFE and bill, and any documentation showing that the difference was based on a medically necessary item or service that could not have been reasonably anticipated when the GFE was provided. Providers and facilities must suspend collections and accrual of late fees on unpaid amounts while the dispute resolution process is pending and must not take or threaten any retributive action for a patient's use of the dispute resolution process. The patient and provider may agree to settle the dispute at any point prior to the resolution of the dispute. The provider is required to notify the dispute resolution entity of the resolution within three business days of the settlement.

Enforcement of GFE Requirement

Providers or facilities that fail to provide GFEs may be subject to enforcement actions including penalties of up to $10,000 per violation. The Centers for Medicare & Medicaid Services (CMS) understands that it may take time for providers and facilities to develop systems and processes for receiving and providing the required information from co-providers and co-facilities. **Therefore, for GFEs provided to uninsured (or self-pay) patients from January 1, 2022 through December 31, 2022, HHS will exercise its enforcement discretion in situations where a GFE provided to an uninsured or self-pay patient does not include expected charges from co-providers or co-facilities**. If items and services provided by a co-provider or co-facility are not included on the GFE or are only a range of charges, they are not eligible for the dispute resolution process until after December 31, 2022.

Interplay with State Laws

The NSA was intended to build upon existing state laws protecting consumers against surprise billing by creating a federal "floor" for consumer protections. According to CMS guidance, if a state has an All-Payer Model Agreement or other state law that determines payment amounts to out-of-network providers and facilities for a service, the All-Payer Model Agreement or state law will generally determine the patient's cost-sharing amount and out-of-network payment rate. Additionally, if states dispute resolution processes meet or exceed NSA minimum requirements, HHS will generally defer to these state requirements and processes. That being said, the NSA minimum requirements can be a high bar. How providers should navigate the cross-section between the NSA and state surprise billing laws and consumer protections remains a source of confusion.

CMS has begun to publish Consolidated Appropriations Act (CAA), 2021, Enforcement Letters to provide more clarity with respect to this interplay by clarifying the No Surprises provisions the state is enforcing independently or through a collaborative enforcement agreement versus the provisions that CMS will enforce. The letters also address the circumstances in which the federal independent dispute resolution and federal patient provider process apply in each state. These letters are based on a June 2021 survey that CMS distributed to states to determine their authority and intention to enforce certain provisions of the NSA. In addition to these Enforcement Letters, further federal guidance, rulemaking, and state laws are anticipated to help providers and practitioners get more clarity regarding NSA compliance and enforcement.

For more information, please contact Mary Grace Griffin, Allison M. Cohen or any member of Baker Donelson's Reimbursement Team.