Blog Post

"The No Surprises Act" a/k/a "The Act that Continues Surprising Providers"

April 25, 2022
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The No Surprises Act (the Act) continues muddling through its implementation period. We have discussed the Act in prior posts, and most recently on March 8, 2022. The surprises have continued, with new updates coming out almost daily! There has been legal movement as health care providers and facilities (collectively, Providers) have brought lawsuits against the Departments of Health and Human Services (HHS), Labor, and Treasury, and the Office of Personnel Management (collectively, Department). In addition, the Centers for Medicare & Medicaid Services (CMS) issued answers to new frequently asked questions (FAQs).

April 4, 2022 – Continued Litigation Movements

As a reminder, on February 23, 2022, the U.S. District Court for the Eastern District of Texas set aside portions of the October 7, 2021 interim final rule with comment period (the Interim Rule) relating to the creation of an Independent Dispute Resolution (IDR) process.

Recently, there has been movement in the U.S. District Court for the District of Columbia case that was brought by the Association of Air Medical Services, the American Hospital Association, and the American Medical Association (collectively, the Plaintiffs) against the Departments. This case also

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involves challenges to the methodology used by the IDR process in calculating the qualifying payment amount (QPA) (the plan's median contracted rate for a particular service). On April 4, 2022, the Plaintiffs filed a Supplemental Brief asking the court to vacate portions of the Interim Rule that contain a presumption in favor of selecting the offer closest to the QPA.

The Plaintiffs further contend HHS has been slow to take any action in response to the Texas decision: "The Departments have neither acquiesced to the decision of the Eastern District of Texas vacating portions of the September Rule, nor suggested any intent to abandon their interpretation of the No Surprises Act in any final rule [...]." For this reason, the Plaintiffs argue that the court should act now, and not wait for the Departments to issue a final rule, because the Departments "do not even guarantee a final rule by May."

The Departments filed their Supplemental Brief on the same day as the Plaintiffs in which they advised that they have begun preparing a final rule that will address those provisions vacated in the Texas decision. They anticipate issuing the final rule early this summer.

April 5, 2022 – FAQs About Good Faith Estimates (GFE) for Uninsured (or Self-Pay) Individuals – Part 2

The next day, April 5, 2022, CMS published these FAQs to provide general information regarding the technical legal standards of GFEs.

The Act requires that Providers inform patients of the GFE of expected charges before providing items or services to uninsured patients and patients who do not plan to submit their claims to their health plans (self-pay patients). A summary of some of the GFE requirements discussed in the recent FAQs are outlined below.

- ***GFE Not Required to Include Future Visits During an Initial Visit.***

    - However, a new GFE which includes expected charges for future services must be furnished following an initial visit upon the patient's request or upon scheduling additional services.

- ***GFE Not Required for Services Scheduled Within Less than Three (3) Business Days Before the Expected Service.***

- ***GFE Must Include Itemized List of Reasonably Expected Charges for the Specific Period of Care.***

    - The GFE may exclude charges for services that could not have been reasonably expected.

    - However, the patient may initiate the patient-provider dispute resolution process if the provider provides services that were *not included in the original GFE* and the difference between the billed charges and the GFE is $400 or more.

April 6, 2022 – FAQs for Providers About the No Surprises Rules

CMS released answers to additional FAQs for Providers pertaining to the Act the very next day. The FAQs discuss a wide range of issues. We discuss a key distinction explained in the FAQs –when the Act requires patients to sign notices.

- ***Signed Acknowledgement NOT Required on the Notice Regarding Patient's Protections Against Surprise Billing.***

    - In general, Providers are required to provide patients with a written disclosure about their balance billing protection
    - Patients are not required to sign an acknowledgement that they received the

notice.

- Providers must:
  - Make the notice publicly available, and (if applicable) post it on the Provider's public website; and
  - Provide a one-page notice that includes information regarding patient protections against surprise billing. CMS provides a Model Disclosure Notice Regarding Patient Protections Against Surprise Billing. Providers are *not* required to use CMS' model notice to meet the disclosure requirements.

- ***Consent and Signature REQUIRED on the Surprise Billing Protection Form.***

  - If an out-of-network Provider wants to balance bill a patient (bill a patient the difference between the billed charge and the amount the patient's plan paid) in circumstances in which it would otherwise be prohibited, the Provider must provide the patient (or authorized representative) with the Standard Notice and Consent Form. This form describes the patient's surprise billing protections and information about the potential costs if the patient waives those protections.

  - A patient is not required to sign the consent form unless the patient is willing to waive their protections and understands or agrees to pay out-of-pocket for balance bills on out-of-network services.

    - However, for a waiver of the balance billing protections to be effective, the patient (or authorized representative) must physically or digitally sign the Standard Notice and Consent Form.
    - CMS' Standard Notice and Consent Form may not be modified, except as

indicated in the form or as may be necessary to reflect applicable state law.

- The form must explicitly identify the individual Provider who is expected to provide the given service. The form may not list a Provider group.

- Caveats regarding the waiver of surprise billing protections:

  - Providers may request the waiver for (1) post-stabilization services, if the conditions discussed below are met, and (2) non-emergency services provided by out-of-network Providers during patient visits to in-network facilities.

    - Out-of-network Providers may balance bill for post-stabilization services only if the attending emergency physician or treating Provider: (1) determines the patient can travel using non-medical or nonemergency medical transportation to an available in-network Provider located within a reasonable travel distance, taking into account the individual's medical condition; (2) determines the patient is in a condition to receive notice and provide informed consent; (3) the Provider provides the patient CMS' Standard Notice and Consent Form within the timeframe outlined in the form and obtains the patient's consent to waive surprise billing protections; and (4) the Provider satisfies any additional state law requirement.

- Providers may not request the waiver for (1) ancillary services (e.g., radiology and laboratory services, anesthesiology, pathology, and neonatology), or (2) services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.

- No waiver is required for non-emergency services provided by out-of-network Providers during patient visits to out-of-network facilities. The federal balance billing prohibitions do not apply to these services. Therefore, patient consent is not required to balance bill these patients.

More changes and updates are expected in the weeks to come. We are available to assist parties seeking guidance regarding adhering to the Act in the midst of this changing legal environment.
