Garfunkel Wild Alert

Connecticut ORTHOPAEDIC Society

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FEDERAL NO SURPRISES ACT – 2023 ENFORCEMENT OF THE GOOD FAITH ESTIMATE FOR CONVENING PROVIDERS AND FACILITIES

OVERVIEW

The No Surprises Act requires providers and facilities to provide uninsured or self-pay individuals with a good faith estimate ("GFE") of expected charges for a scheduled or requested item or service. While the overall requirement is already in effect as of January 1, 2022, the Department of Health and Human Services (the "Department") recognized that it would take time for facilities and providers to establish efficient procedures to implement the full extent of the GFE requirements, especially as it relates to the coordination between different providers or facilities. As such, the Department issued guidance on December 21, 2021,[1] stating that it would exercise its discretion as to enforcement for the specific elements related to convening providers or convening facilities through the end of 2022. After issuing this guidance, the Department continued to receive feedback indicating that providers and facilities would need more time in order to work through the technical complexities of coordinating between multiple providers and facilities. Therefore, the Department revised its guidance again on December 2, 2022, further extending its enforcement discretion pending future rulemaking, which will include a prospective applicability date so that providers and facilities have a reasonable amount of time to comply with any new requirements.[2]

WHO MUST THE PROVIDER OR FACILITY PROVIDE WITH A GFE?

A provider or facility must provide a GFE to any uninsured or self-pay individual. This includes (a) individuals who do not have benefits for an item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, Federal health care program, or a health benefits plan under chapter 89 of title 5, United States Code, or (b) an individual who has benefits for the item or service under one of the aforementioned categories but does not seek to have a claim for the item or service submitted to the plan for coverage.[3] Therefore, if a patient is insured, the item or service is covered by their plan, and a claim is being submitted for payment to the patient's plan, there is no need for a GFE. However, if the patient is insured and the item or service is covered by their plan, *but the patient is choosing to self-pay and a claim is not being submitted to the plan*, then a GFE must be provided. This requirement is unrelated to whether or not a provider is employed by a facility where the services are being provided, but rather hinges on the availability of coverage under, and a provider's participation status in, an individual's benefits plan.

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[1] *Guidance on Good Faith Estimates and the Patient-Provider Dispute Resolution (PPDR) Process for Providers and Facilities as Established in Surprise Billing, Part II; Interim Final Rule with Comment Period (CMS 9908-IFC)*; December 21, 2021; https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimate-Patient-Provider-Dispute-Resolution-Process-for-Providers-Facilities-CMS-9908-IFC.pdf

[2] *FAQs About Consolidated Appropriations Act, 2021 Implementation – Good Faith Estimates (GFEs) for Uninsured (or Self-Pay) Individuals – Part 3*; December 2, 2022; as available on https://www.cms.gov/files/document/good-faith-estimate-uninsured-self-pay-part-3.pdf on January 12, 2023

[3] 45 CFR 149.610(a)(2)(xiii)

The Department has provided a template for providers to use in providing the GFE.[4] The GFE must be provided, either in a paper or electronic format, no later than 3 days after the patient requests it. For visits scheduled less than 3 day in advance, the GFE must be provided no later than 1 business day after scheduling.

WHO IS RESPONSIBLE FOR PROVIDING A GFE WHEN THERE ARE MULTIPLE PROVIDERS AND FACILITIES INVOLVED?

At this point in time, each individual provider is responsible for providing his/her own GFE. While the original provisions of the GFE required coordination between all the providers and facilities that may be involved in providing an episode of care, the Department has announced that it is currently not enforcing these guidelines pertaining to convening providers and convening facilities. In summary, a convening provider or convening facility is one who is scheduling the item or service or who received the initial request for the GFE from an individual ("Convening Entity"). Since the GFE must include an itemized list of the items and services to be provided, the requirements of the No Surprises Act originally called for the Convening Entity to obtain the amount of expected charges from any co-provider or co-facility providing items or services in connection with the requested GFE ("Supporting Entities"). The Department has now delayed enforcement of this provision twice. Convening Entities should note that although they do not need to include a Supporting Entity's services or items in its GFE, should a Convening Entity choose to include this information in the GFE, those services or items would become eligible for the Patient-Provider Dispute Resolution ("PPDR") process. If a Supporting Entity's services or items are not included in a GFE, or do not appear as a range of expected charges, those services or items are not eligible for the PPDR process.

If and when the Department chooses to enforce this requirement, then upon the request for a GFE, the Convening Entity would need to contact, within one (1) business day of the request, all Supporting Entities who are reasonably expected to provide items or services in conjunction with the primary requested item or service. The request must also include the date by which it must receive the information from the Supporting Entities.[5] The information from the Supporting Entities is then included in the GFE for the individual. If the Convening Entity anticipates or is notified of a change that would impact the amounts included in the GFE, it must reach back out to the Supporting Entities and provide an updated GFE to the individual at least one (1) business day before the items or services are scheduled to be furnished.

The Department expressed that its reason for extending its enforcement discretion is based on the belief that providers and facilities will need to adopt a market-wide standards-based application programming interface (API) in order to successfully implement the appropriate coordination between multiple providers and facilities. This will need to be part of a larger strategy in the future, requiring the Department to promote and develop further interoperability across the health care industry.

WHAT PENALTIES ARE ASSOCIATED WITH A FAILURE TO ADHERE TO THE GFE REQUIREMENTS?

Each state is tasked with enforcement of the requirements of the No Surprises Act. Where the Department has determined that a state has failed to appropriately enforce these requirements[6] or in states where the Department is directly enforcing the balance billing provisions, the Secretary of the Department (the "Secretary") may impose civil monetary penalties. Penalty amounts may not exceed $10,000 per violation[7]

[4] Available at https://www.cms.gov/nosurprises/consumers/understanding-costs-in-advance as appearing on January 12, 2023
[5] 45 CFR 149.610(b)(1)(v)
[6] 42 U.S.C.A. § 300gg-134(a)
[7] 42 U.S.C.A. § 300gg-134(b)(1)

and the Secretary must waive the penalties if the provider or facility did not knowingly violate the requirements and the provider withdraws the bill and reimburses any amounts exceeding the permitted amount, including interest at a rate determined by the Secretary.[8]

In general, if the actual charges exceed the expected charges provided in a GFE by at least $400,[9] the dispute is eligible for the PPDR process.[10] If the Selected Dispute Resolution ("SDR") entity determines that there was no credible information proving that the charge discrepancy is based on medically necessary items or services provided due to reasonably unforeseen circumstances, the SDR entity must determine that the amount to be paid for the item or service would be $0.[11] Additionally, in the event the patient prevails in the PPDR process, the provider would also be responsible for the SDR administrative fee, which is currently limited to $25.

DOES CONNECTICUT HAVE ADDITIONAL REQUIREMENTS RELATING TO THE GFE?

Connecticut passed its own surprise billing law in 2015 that applies to all fully insured health plans regulated by the Connecticut Insurance Department,[12] however the Connecticut Insurance Department has not made any changes, taken any action, or made any regulatory updates that would impact the requirements for GFEs under the Federal No Surprises Act.

If you have questions about this Alert, please contact one of the authors listed below or the Garfunkel Wild attorney with whom you regularly work:

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[8] 86 FR 36872, Section IV(A)(1), *Requirements Related to Surprise Billing; Part I*; published July 13, 2021

[9] Department of Health and Human Services, *Learn more about the Good Faith Estimate and the Patient-Provider Dispute Resolution (PPDR) process for people without insurance or who plan to pay for the costs themselves*, December 21, 2021; https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/good-faith-estimate-patient-provider-dispute-resolution-process-for-uninsured-or-self-pay-individuals.pdf

[10] 45 CFR 149.620(b)(1)

[11] Department of Health and Human Services, *Guidance for Selected Dispute Resolution (SDR) Entities: Required Steps to Making a Payment Determination under the Patient-Provider Dispute Resolution (PPDR) Process*; https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Selected-Dispute-Resolution-Entities-Required-Steps-Making-Payment-Determination-Under-Patient-Provider-Dispute-Resolution-Process.pdf

[12] Conn. Gen. Stat. §§ 38a-477aa and 20-7f