Key Requirements in Part II of the Surprise Billing Rule and New Resources

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Political Overview

This latest iteration of the regulations implementing the No Surprises Act once again tilts in favor of insurers and against health care providers. This is most notable in the establishment of a rebuttable presumption that the Qualifying Payment Amount (QPA) is the appropriate payment rate for out-of-network providers. The guardrails that were put in place during the hotly debated development of the underlying statute to ensure that additional factors would be considered are swept aside in this rule. These additional factors are now to be used to rebut the presumption that the QPA is the correct amount, and only where it can be proven that they are not already included in the QPA and are material to the item or service provided to the patient.

This is one issue that we expect Members of Congress, led by Rep. Suozzi (D-NY) and Rep. Wenstrup (R-OH), to raise in a letter to the federal agencies. We hope to have a draft next week. In the interim, House Ways and Means Committee Chair Neal and Ranking Member Brady have written to the agencies expressing their concerns with the emphasis on the QPA. Click here for the letter. However, their letter also pushes for implementation of regulations this year on the good faith estimate and advanced explanation of benefits for all patients. Other key Members of Congress are weighing in with support. Click here for a press release from House Energy and Commerce Committee Chairman Pallone and Senate HELP Committee Chairman Murray.

We will keep you posted on additional Congressional efforts and any likelihood of changes or delays to the regulations. Changing any of these requirements at this point will be a very heavy lift. This memo will guide you through the various resources available and summarize key provisions in the latest regulation.

Summary of New Resources

The federal agencies responsible for implementation of the No Surprises Act unveiled new websites:

- Click here for the new CMS surprise billing website. This site will be populated throughout the fall with additional information for providers, insurers, and patients. The application process for entities seeking to be certified as Independent Dispute Resolution

(IDR) entities is open and HHS will have entities certified to accept disputes beginning January 1, 2022.

- Click here for a CMS zip file containing standard forms for good faith estimates and the Select Dispute Resolution (SDR) process.

- Click here for the new Department of Labor surprise billing website – this site includes all the notices required for use of the new Independent Dispute Resolution process.

Click here for the PDF of the Interim Final Rule for Part 2 of the Surprise Billing requirements; page references below are to this version. **Comments are due no later than 5:00 PM ET on December 6, 2021.**

Click here for the HHS Press release, here and here for fact sheets on the rule, here for the unpublished 521-page Interim Final Rule and here for our previous memo.

Key Requirements

This memo addresses three main parts of this IFR:

- the IDR process which is the process for providers/facilities and payers to resolve payment disputes (including treatment of batched claims and IDR fee structure),
- the good faith estimates that will be required for patients or prospective patients who are uninsured or self-pay, and
- the SDR process for uninsured/self-pay patients whereby the patient may dispute fees in excess of the good faith estimate.

Rulemaking regarding the good faith estimates and advanced explanation of benefits for insured patients/prospective patients is deferred until next year. Click here for August 20 HHS notice.

IDR Process – *overview begins on page 8 of the PDF*

A federal IDR portal will be established to receive requests from providers and insurers to resolve disputes and it will also be used by IDR parties and IDR entities to satisfy reporting requirements. Click here for the information that must be reported. The federal IDR portal will also be used for the Select Dispute Resolution (SDR) process (whereby an uninsured/self-pay patient may challenge a bill that exceeds the good faith estimate) described later in the memo.

- Out-of-network providers and payers have 30 days to engage in private, voluntary negotiations to resolve payment disputes.
- If negotiations fail, either party may initiate the IDR process within 4 days.
- Each party offers a payment amount and the IDR entity selects one amount or the other.
- There is a rebuttable presumption that the Qualifying Payment Amount (QPA), the plan's median in-network rate) is the "correct" amount. The statute defined numerous additional factors to be considered in determining the payment amount including:

    - The level of training, experience, quality and outcomes measurements of the provider or facility that furnished such item or service;
    - The market share held by the nonparticipating provider or facility or that of the plan or insurer in the geographic region;
    - The acuity of the individual or the complexity of furnishing the item or procedure;
    - The teaching status, case mix or scope of services of the nonparticipating facility
    - Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider or facility and the plan or issuer during the previous 4 plan years.
- The IFR provides that these additional factors may be considered to rebut thepresumption that the QPA is the correct amount, provided that the evidence is credible that these factors are not already accounted for in the QPA and that these factors were necessary for the care that was provided.
- IDR entities may not consider the usual and customary charge or the billed charge or reimbursement by public payers.
- The losing party is responsible for the fees; if the case is settled, the costs are split equally unless the parties agree otherwise.
- The party initiating IDR is prevented from taking the same party to arbitration for the same item or service for 90 days after a decision.
- Specifies timelines for each step in the process.
- Decision is binding unless there is fraud or evidence of intentional misrepresentation of material facts.

Treatment of Batched Claims – *see discussion beginning on page 15 of the PDF*

- Must involve the same provider (same NPI or TIN) and the same insurer.
- Must involve the same or similar items for treatment of the same or similar medical condition (billed under the same service code or a comparable code under a different procedural code system; CPT, HCPCS or DRG codes.
- Must occur within the same single 30-business-day period or the 90-calendar day suspension period (used for low-volume items and services).
- Bundled claims, where multiple services received by an individual during an episode of care, may be submitted.
- Certain batched items and services may have different QPAs requiring the parties to provide relevant information for each QPA and the IDR will consider each separately.

IDR Fees – *see page 22 of the PDF*

Click here for the fee guidance for 2022. For 2022, the administrative fee is $50. The IDR entities will set their respective fees but must generally adhere to the range set in annual guidance. For 2022, this range is $200 to $500 for a single determination and $268 to $670 for batched determination.

Each party must submit the entity fee upon submitting an offer. The amount is held in trust until the IDR makes its determination. The wining party receives a refund while the losing party forfeits the fee. For batched claims, the party with the fewest determinations in its favor is the losing party.

Good Faith Estimates for Uninsured/Self-Insured Patients – *see overview beginning on page 34 of the PDF*

While the preparation of a good faith estimate applies in this IFR to a narrow group of individuals, it may be instructive as to the Departments' future rulemaking (expected next year) on good faith estimates for insured patients. This IFR applies only to uninsured or self-pay individuals, including individuals enrolled in short-term, limited-duration insurance. The good faith estimate requirement is triggered when the patient schedules the health care services or when the individual requests the information.

- Good faith estimates for uninsured and self-pay patients or prospective patients will be required effective 1/1/22.
- Defines "convening health care provider or convening health care facility" as the provider or facility who receives the initial request for a good faith estimate from an uninsured (or self-pay) individual AND who is, or who would be, responsible for scheduling the primary item or service. The convening provider is responsible for determining if the individual meets the definition of uninsured or self-pay and for providing the good faith estimate. Also responsible for contacting all applicable co-providers and co-facilities within 1 business day after the request for a good faith estimate is received or after the primary item or service is scheduled. *See pages 36-39 for more.*
- Defines time frames for gathering all the info and submitting to the individual.
- Defines content of the good faith estimate. *See page 39 for details; standard forms are included in the CMS zip file, Appendices 1 and 2.*
- Defines "co-health care provider or co-health care facility" as a provider or facility other than a convening provider or facility that furnishes items or services that are customarily provided in conjunction with a primary item or service. *See pages 36-39 for more.*
- To give providers time to develop a system for coordinating all the information required from various providers, HHS will exercise enforcement discretion through December 31, 2022 where the good faith estimate does not included expected charges from a co-provider or co-facility.
- Expected charge means the cash pay rate or rate established by provider or facility for an uninsured (or self-pay) individual, reflecting any discounts or other relevant adjustments for such individuals for each item or service; or the amount the provider or facility would expect to charge if the provider or facility intended to bill a plan or issuer directly for such item or service.
    - "Items or services" includes all encounters, procedures, medical tests, supplies, prescription drugs, durable medical equipment, and fees (including facility fees) provided or assessed in connection with the provision of medical care.
    - "Period of care" means the day or multiple days during which the good faith estimate for care is furnished or anticipated to be furnished; includes the period of

time during which any facility equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services that would not be scheduled separately by the individual, are furnished.
  - The good faith estimate is not required to include charges for unanticipated items or services that are not reasonably expected and that could occur due to unforeseen events.
  - HHS is seeking comment on whether providers and facilities should be required to include both the list price and discounted price for an item or service when discounts apply.

Patient-Provider Dispute Resolution – SDR Process – *discussion begins on page 45 of the PDF*

- Eligible where the total billed charges are "substantially in excess" defined as $400.00 more than the total amount of estimated charges.
  - Any item or service not included in the good faith estimate that results in the total billed charges exceeding $400 over the estimate, is also eligible for dispute resolution.
  - For items and services that were not included in the good faith estimate, the provider/facility must provide credible evidence that the billed charge reflects the cost of medically necessary care and is based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility when the estimated was provided.
  - HHS is seeking comment on whether uninsured/self-pay should be able to initiate dispute resolution for good faith estimates they believe to have been overinflated in order for providers and facilities to avoid dispute resolution.
  - If the provider/facility satisfies this standard, the patient must pay the LESSER of the billed charge or the amount that a plan or insurer would have paid (what would have been the QPA).
- Only the uninsured/self-pay patient may initiate SDR. The patient pays a $25 fee which is refundable (and paid by the provider) where the patient prevails. HHS pays for the SDR costs and contracts directly with the SDR entity. HHS anticipates contracting with 3 nationwide SDR entities for 2022.
- Patients have up to 120 calendar days after receipt of the bill to notify HHS through the federal IDR portal of their intent to begin SDR. Bills may not be moved into collection and late fees may not be imposed while the process is pending.
- When a state law is in effect that provides a process for resolving these disputes, state law will apply if it meets or exceeds the consumer protections contained in federal law. HHS will determine whether a state patient-provider dispute resolution process provides at least the same level of consumer protection.

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