**Requirements Related to Surprise Billing – Part II**

CHA Summary

Internal

On Oct. 7, the Departments of Health and Human Services (HHS), Treasury and Labor, with the Office of Personnel Management issued a [joint interim final rule (IFR) with request for comment](https://www.govinfo.gov/content/pkg/FR-2021-10-07/pdf/2021-21441.pdf) that implements provisions in the [No Surprises Act](https://www.childrenshospitals.org/content/public-policy/federal-guidance/surprise-billing-rules) related to the independent dispute resolution (IDR) that will be used to determine the out-of-network payment rate when negotiations between a provider and insurer are unsuccessful in surprise billing situations. The rule also partially implements the act’s requirements that providers give certain patients good faith estimates of the costs of their care, as well as a dispute resolution process for situations where an uninsured or self-pay patient receives a good faith estimate and then is billed for an amount substantially in excess of the estimate.

The No Surprises Act protects enrollees covered by private insurance from surprise medical bills when they receive emergency services, non-emergency services from out-of-network providers at in-network facilities, or air ambulance services from out-of-network air ambulance services. The act does not apply to public payers, short-term limited duration plans and other types of limited insurance, but does apply to the Federal Employees Health Benefit Plan.

The detailed summary below highlights provisions in the IFR with implications for children’s hospitals, as well as selected requests for comment that are included in the rule. We also seek children’s hospitals’ feedback on the following issues, in addition to all aspects of the rule.

* The rule implements the law’s IDR process in such a way that it effectively establishes a de facto benchmark payment rate for out-of-network emergency and certain non-emergency services that are subject to the act’s surprise billing protections by requiring arbiters to give undue weight to the median contracted rate for similar services and providers in the geographic area when making the final payment decision.
	+ **We are concerned that the emphasis on the median contracted rate could disincentivize insurers from contracting with children’s hospitals or lead to artificially low rates, and seek children’s hospitals’ feedback on current and anticipated challenges negotiating with payers.**
* The rule implements the law’s requirement that providers give a good faith estimate to certain patients, limiting it to uninsured and self-pay patients including those who are shopping for services. Future rulemaking will require providers to furnish good faith estimates to patients and their plan for inclusion in an advanced explanation of benefits.
	+ **We seek children’s hospital feedback on the required content of the good faith estimates, as well as the process to develop the estimate and provide it to patients and their families.**

The IFR is effective now and will generally apply to the insurance plan year that begins Jan. 1, 2022, but the departments are accepting comments until **COB Dec. 6**. Children’s hospital feedback should be sent to Jan Kaplan **by COB, Nov. 8.**

| **Issue** | **Key Provisions**  | **Departments’ Requests** **for Comment** | **Children’s Hospital****Feedback** |
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| **Open Negotiation Period to Resolve Payer/Provider Payment Disputes** | In a surprise billing situation, a payer or provider/facility may initiate a 30-day negotiation period by providing a written notice to the other party within 30 business days of initial payment or denial. Parties must use a [standard notice](https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-2.pdf), which must be sent electronically and include the item or service; the date it was furnished; the service code; the initial payment amount or notice of denial of payment; and contact information. The 30-business-day open negotiation period begins the day the notice is sent.  | The departments seek comment on any challenges with designating the beginning of the open negotiation period as the date the notice is sent.  |  |
| **Independent Dispute Resolution (IDR) Process** **Initiation of IDR Process** | In the event a payment amount is not agreed to during the open negotiation period, either party may initiate IDR during the 4-business-day period that immediately follows the end of the negotiation period. The party initiating the IDR must submit a notice (the “[Notice of IDR Initiation](https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-3.pdf)”) to the other party and the departments through a federal IDR portal. The notice must include, among other things: * dates and location of the items or services; corresponding service and place-of-service codes; the amount of allowed cost-sharing; and the initial payment amount.
* the initiating party’s preferred IDR entity.
* the qualifying payment amount (QPA), which is the issuer’s median in-network rate for 2019 for the same or similar item or service provided by a provider in the same or similar specialty and in the geographic region in which the item or service is furnished, increased for inflation.[[1]](#footnote-1)

The IDR process is initiated upon the receipt of the notice by the departments.  |  |  |
| **IDR Process** **Selection of the IDR Entity**  | Both parties must agree on the entity that will serve as arbiter (“IDR entity”) and notify the departments, via the portal, of their joint selection within four business days of the initiation of the IDR process. * If the opposing party objects to the preferred entity, they must provide an explanation and propose an alternative.
* If the parties fail to agree on an entity within three business days, the departments will randomly select the entity.

The IDR portal will include a list of certified IDR entities. Selected entities must not have a conflict of interest. * Certified entities will be organizations with sufficient staff with arbitration and health care claims experience, including those that are currently provided external review of state IDR determinations.
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| **IDR Process** **Authority to Continue Negotiations after Beginning of IDR Process** | If the two parties agree on a payment amount after IDR has started, that amount will be treated as the out-of-network payment amount. * Notice of an agreement must be provided to the departments via the portal within three business days of the date of the agreement.
* The amount by which the agreed-upon payment rate exceeds the cost-sharing amount is the total plan amount. The plan must pay the balance to the nonparticipating provider/facility within 30 days.
* Each party must pay half of the IDR fees.
* Neither party may seek additional payment from the patient if the final payment amount exceeds the QPA.
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| **IDR Process** **Submission of Offers** | Within 10 business days of the selection of the IDR entity, both parties must submit (via the portal) a payment offer to the entity, expressed as a dollar amount and a percentage of the QPA for that item or service. They must also provide any other information requested by the entity.* Providers/facilities must:
* Indicate the number of employees in their facility or practice.
* Specify their practice specialty or type.
* Plans must:
* Provide their coverage area.
* Indicate the relevant geographic area that was used to determine the QPA.
* Indicate whether they are fully insured, partially insured or self-insured.

Both parties may submit other relevant information, but may not include information that relates to usual and customary charges, billed amounts or public payer rates.  | The departments seek comment on whether additional guidance is needed on how hospitals or practices that do not employ their medical staff should report their number of employees. |  |
| **IDR Process** **QPA as Presumed Appropriate Final Payment Amount** | The IDR entity must choose one of the offers within 30 days of their selection as the entity. When choosing between the two offers, the IDR entity must:* Start with the presumption that the QPA is the appropriate out-of-network rate for the item or service.
* Consider the additional relevant information submitted by either party only if that information is “credible” and relates to the offer.
	+ The rule specifies that the information is credible if it is worthy of belief and is trustworthy based on critical analysis.
* Select the offer that is closest to the QPA, unless the credible information submitted by one of the parties demonstrates that the QPA is materially different from the appropriate out-of-network rate.
	+ The rule specifies that the QPA would be “materially different” if there is a substantial likelihood that someone with the IDR entity’s qualifications would consider the information provided as important in determining the rate and shows that the QPA is not the appropriate rate.
* When the IDR entity determines a material difference between the QPA and the appropriate rate or when the two offers are equally distant from the QPA but in opposing directions, the offer that best represents the value of the items or services must be selected.
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| **IDR Process** **Consideration of Additional Factors**  | The rule specifies when credible information related to any of the additional arbitration factors required to be considered under the act[[2]](#footnote-2) may or may not demonstrate that the QPA is materially different from the appropriate out of-network rate. * Level of training, experience, and quality and outcome measurements.
	+ According to the rule, a higher out-of-network rate than the QPA is not warranted simply based on the provider’s level of experience or training.
	+ The IDR entity should consider whether to select a higher rate than the QPA when a provider/facility has received quality/outcome-related bonus payments.
	+ The entity should consider whether to select a lower rate than the QPA if the provider/facility has been subject to a quality/outcome-related penalty payment.
* Market share.
* IDR entities should take into account the influence that market dominance of a provider or a plan can have on reimbursement rates.
	+ A plan with a large market share may drive down rates, in which case an out-of-network rate higher than the QPA may be warranted.
	+ Providers with a large market share may drive up rates and a lower out-of-network rate than the QPA might be warranted.
* Patient acuity or complexity of furnishing item or service.
	+ Only in rare instances would the QPA not adequately account for patient acuity or service complexity because service codes and modifiers that reflect patient acuity and service complexity were incorporated into the calculation of the QPA. Exceptions include:
		- When the complexity of the case requires time or intensity of care that exceeds what is typical for that service code.
		- When a plan applies a QPA that uses a different service code or modifier than those submitted by the provider. In this situation, the provider could submit credible information showing that the QPA does not reflect patient acuity or service complexity.
* Teaching status, case mix, and scope of services of the nonparticipating facility.
	+ The characteristic of the teaching status, case mix or scope of services can only be considered if it, in some way, is critical to the delivery of the item or service and was not accounted for in the QPA.
* For example, the IDR entity could consider the trauma level of a hospital when the dispute involves trauma care that could not be performed at a lower-level hospital, but only to the extent the QPA does not otherwise reflect this factor.
* Demonstrations of good faith efforts (or lack thereof) to enter into network agreements, and contracted rates between the provider and the plan during the previous four plan years.
	+ The IDR entity must consider what the contracted rate might have been had the good faith negotiations resulted in the provider being in-network.

The IDR entity is prohibited from considering usual and customary charges, billed charges, or public payers’ reimbursement rates for the item or service under dispute.  | The departments intend to provide additional guidance to certified IDR entities as necessary to clarify how the allowable factors should be considered and seek comment on this approach, including:* the appropriateness and scope of the factors previously discussed.
* whether additional requirements should be considered to address potential gaming of the IDR and/or scenarios where parties could potentially distort information, such as overestimating the teaching experience of providers at a facility or upcoding the costs of services.
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| **IDR Process** **Reporting and Implementing Final Payment Decision** | The IDR entity must submit a written decision on the final payment rate to the departments.* If the offer closest to the QPA is not chosen, the written report to the departments must include a detailed explanation of the additional considerations that were relied upon and the basis upon which the entity determined that the credible information provided demonstrated that the QPA is materially different from the appropriate out-of-network rate.

The payer must make any payments due to the provider as a result of the final payment determination within 30 calendar days of the final decision. * The final payment will be reduced by the amount already paid to the provider and any cost-sharing paid by the patient. The final payment determination does not change the patient’s cost-sharing obligation, which is based on the QPA.
* The provider must remit to the payer any extra cost-sharing that was paid by the patient within 30 calendar days of the final payment decision.

The party that initiated the IDR process is prohibited from initiating another IDR involving the same other party with respect to the same or similar item or service for 90 calendar days following the final payment determination.  |  |  |
| **IDR Process****Reporting Requirements** | Each month, IDR entities must report to the departments certain data on final payment determinations, which will be included in quarterly reports posted on a public website. Datapoints include: * The types of items or services
* Each party’s name and address
* The relevant geographic region for purposes of the QPA
* The practice specialty or type and size in terms of employees
* The offers submitted by each party as both a dollar amount and percentage of the QPA
* Whether the selected offer was submitted by the plan or the provider
* The rationale for the decision, including if it was based on criteria other than the QPA
* The number of times the final payment rate exceeded the QPA
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|  **External Review of Adverse Benefit Determinations** | The rule broadens the scope of state and federal external review requirements to the review of any adverse benefit determination that relates to a plan’s compliance with the surprise billing and cost-sharing protections of the act.  |  |  |
| **Good Faith Estimates for Uninsured/Self-pay Patients[[3]](#footnote-3)**  | Uninsured and self-pay patients[[4]](#footnote-4) (or their authorized representative) must be given a good faith estimate of potential charges, including for items and services that are reasonably expected to be provided in conjunction with care.* The estimate must be given prior to all scheduled services or by request if the patient is shopping for care and has not yet at the point of scheduling.
* Any discussion or inquiry regarding the potential cost of items or services under consideration should be interpreted as a request for an estimate.
* The estimate must include the expected billing and diagnostic codes and the expected charge (cash pay rate) for each item or service, including any available discounts or other relevant adjustments.
* The good faith estimate must encompass:
* The day(s) during which the primary item(s) or service(s) are delivered.
* All items or services that are reasonably expected to be provided with the primary item or service, including those that may be provided by other providers and facilities (such as laboratory, imaging, pre- and post-operative services) that would not be scheduled separately.

The provider/facility that is responsible for scheduling the primary item or service or receives the initial request for a good faith estimate (“convening provider”) is responsible for:* Informing (verbally and in writing) uninsured and self-pay patients of the availability of a good faith estimate, using an accessible format and the language spoken by the individual[[5]](#footnote-5)
* Coordinating the estimates from all providers that will be involved in the delivery of relevant items or services to the patient and delivering the estimate to the patient.

The good faith estimate is considered part of a patient’s medical record. | HHS seeks comment on: * whether providers should be required to include both the list price and discounted price for an item or service when discounts apply.
* alternative options for informing uninsured/self-pay individuals of the availability of a good faith estimate.
* challenges related to the secure transmission of good faith estimate information between providers/facilities and whether any standardized processes exist, or could be developed, to facilitate the efficient transmission of this information.
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| **Good Faith Estimates for Uninsured/Self-pay Patients****Timelines** | The convening provider must request good faith estimate information from all other relevant providers within one business day and must receive that information from the other providers within one business day after making the request. The complete good faith estimate must be given to the patient within one business day for a scheduled service that will take place 3-9 days later and within three business days if the scheduled service will take place 10 or more days later or has not yet been scheduled.A single estimate can be provided for recurring services (e.g. physical therapy) for a period up to 12 months. | HHS seeks comment on How the sharing of information on expected charges between the convening and other providers can be accomplished, given no established process exists.  |  |
| **Good Faith Estimates for Uninsured/Self-pay Patients****Content of Estimate**  | The estimate must be provided in writing, either on paper or electronically based on the patient’s preference, and must include: * Patient’s name and date of birth.
* Description of service(s) and date the primary services are scheduled.
* Itemized list of services, grouped by provider or facility, reasonably expected to be provided in conjunction with the primary services for that period of care, with applicable diagnosis and service codes, and the charges associated with each service.
* Name, the National Provider Identifier number and Tax Identification Number of each provider, and the state and facility location(s) where care will be provided.
* List of services that the convening provider anticipates will require separate scheduling.
* Certain disclaimers that indicate that additional services may be recommended as part of the course of care that are not reflected in the estimate; the estimate is not a contract; and the patient’s right to initiate a dispute resolution process.

The estimate does not have to include charges for unanticipated items or services that are not reasonably expected. | HHS seeks comment on:* the benefits, challenges and resources that could facilitate provision of an expanded good faith estimate, which could include expected charges for items and services that are anticipated to be furnished prior to or following the period of care for the primary item or service, but which require separate scheduling by the individual.
* how the requirements under the [Hospital Price Disclosure final rule](https://www.childrenshospitals.org/content/public%20policy/fact%20sheet/federal%20hospital%20and%20payer%20price%20disclosure%20requirements) for the posting of standard charges might be leveraged to provide the good faith estimate.
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| **Good Faith Estimates for Uninsured/Self-pay Patients****Patient-Provider Dispute Resolution Process** | Patients may initiate a dispute resolution process if the total billed charge for a particular provider/facility is at least $400 higher than the combined good faith estimates of charges for that provider/facility. * Patients will have 120 days from the receipt of a bill to request dispute resolution.
* To resolve the dispute, an entity selected by HHS will review documentation submitted by the patient or provider and make a determination as to whether the provider has provided credible information to show that the difference between the billed charge and the expected charge:
	+ reflects the costs of medically necessary care.
* is based on unforeseen circumstances that could not have reasonably been anticipated when the estimate was provided.
* If the dispute resolution entity finds that the provider’s explanation for the difference between the estimate and the charge is credible, the entity must select the amount that the patient must pay, which will be the less of the billed charge or the median payment amount for the same or similar item or service in the geographic area.
* If the entity finds that the information from the provider is not credible, the payment amount will be equal to the expected charge in the good faith estimate.
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1. The QPA is also used to determine patient cost-sharing. [↑](#footnote-ref-1)
2. Under the act, the arbiter must choose between the payer’s and provider’s payment offers taking into consideration the median contracted rate for similar services and providers in the geographic area and other factors such as facility type, prior payment history, patient acuity, case mix, quality measurements, and provider training. [↑](#footnote-ref-2)
3. HHS will exercise enforcement discretion regarding provider compliance with the good faith estimate requirements until Dec. 31, 2022. Future rulemaking will implement the requirement that providers furnish good faith estimates to patients and their for inclusion in the advanced explanation of benefits. [↑](#footnote-ref-3)
4. Patients enrolled in short-term limited duration plans, health care ministries and other products not considered to be minimum essential coverage are considered to be uninsured/self-pay for purposes of this rule. [↑](#footnote-ref-4)
5. HHS is developing a model notice that providers may choose to use to inform patients of the availability of the estimate. [↑](#footnote-ref-5)