July 23, 2021

Requirements Related to Surprise Billing – Part I

CHA Summary

Internal

On July 13, the Departments of Health and Human Services, Treasury and Labor, as well as the Office of Personnel Management issued a joint interim final rule (IFR) with request for comment that implements provisions of the No Surprises Act. The 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 Medicaid, Medicare, TRICARE, short-term limited duration plans and other types of limited insurance, but does apply to the Federal Employees Health Benefit Plan.

This IFR—the first of several rules that will be issued related to the act—implements provisions related to:

- The ban on balance billing for certain out-of-network emergency and non-emergency services.
- How a qualifying payment rate (QPA) must be calculated for the purposes of determining patient cost-sharing obligations and consideration during an independent dispute resolution (IDR) process to adjudicate payer/provider payment disputes.
- Claims processing timelines.
- The notice and consent process that providers must use to notify patients of their rights under the act.
- Consumer complaints and agency enforcement.

Future rulemaking is expected later this year to implement the act's provisions related to the IDR and requirements that providers give patients a "good faith estimate" of the cost of their care and insurers provide enrollees with an advanced explanation of benefits.

While we seek your feedback on all aspects of the rule, we are especially interested in hearing from you regarding:

- The QPA calculation, particularly the definitions of "same or similar item or service," "provider in the same or similar specialty" and "same or similar facility type," and the calculation when there is insufficient information.
- Notice and consent timelines and procedures.
- Claims processing timelines and the possible establishment of a minimum payment rate.

Children's hospital feedback on these proposed revisions rule should be sent to Jan Kaplan by COB, Aug. 6. The IFR goes into effect on Sept. 13 and applies to the insurance plan year that begins Jan. 1, 2022, but the departments are accepting comments until **COB Sept. 7**.

The following summary highlights provisions in the final rule with implications for children's hospitals.

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Issue	Key Proposed Provisions	Departments' Requests for Comment	Children's Hospital Feedback
Coverage of Emergency Services	Requires plans to cover emergency services without any prior authorization, regardless of the network status of the provider or any other term or condition of the plan. • Plans may not impose any administrative requirement or limitation on coverage from out-of-network providers that is more restrictive than the requirements or limitations that apply to in-network providers.		
Definitions of Emergency Conditions and Services	• **Emergency medical condition, emergency services** and **to stabilize** are defined using the same prudent layperson definition as under the Emergency Medical Treatment and Labor Act. • **Emergency services** include those in an emergency department of a hospital or an independent freestanding emergency department (ED), as well as post-stabilization services in certain instances (see below). o Only urgent care centers that are permitted under state licensing laws to provide emergency services are subject to the act. o Plans may not limit coverage of emergency services based on: ▪ Diagnostic codes only. ▪ A time limit between the onset of symptoms and the presentation of the enrollee at the ED. ▪ The final diagnosis only. Instead, determination of whether the prudent layperson standard has been met must be based on all pertinent documentation and be focused on the presenting symptoms. ▪ The fact that the patient did not experience a sudden onset of the condition. o Plans that do not cover maternity care for pregnant dependents cannot deny ED services for a pregnant dependent. • **Post-stabilization services** include services provided after the patient is moved out of the ED and admitted, including any additional items and services covered under the plan and furnished by the provider. o These services are subject to the act's protections until the point of discharge, transfer, or consent by the patient to be balance billed. o Patients may only be transferred if they are sufficiently stable to travel using nonmedical transportation or non-emergency medical transportation to an available in-network provider located within a	The departments seek comment on the following: • Whether there are any additional conditions that would be appropriate to designate under the definition of emergency services, such as conditions relating to coordinating care transitions to participating providers and facilities. • Other facilities that would be appropriate to designate as health care facilities, such as urgent care centers or retail clinics.	

	reasonable travel distance, as determined by the physician. Patients should be involved in that decision-making if possible. o Providers must take into account all relevant information when determining the ability of the individual to be transferred, including: ▪ Whether the individual would face unreasonable travel burdens (including safety, lack of money, etc.) that could prevent them from being able to travel. ▪ Whether the individual (or the individual's authorized representative) is in a condition to understand they are being transferred or consent to potential balance billing if they do not wish to transfer (taking into account their mental and emotional state, mental or behavioral conditions, accessibility challenges, language, and literacy barriers). ▪ Applicable state laws that may impose stricter restrictions on post-stabilization transfers and/or other exemptions from the act's protections.		
Treatment of Single Case Agreements	Non-emergency services furnished by an out-of-network provider at a health care facility that has a single case agreement for the individual being treated, are subject to the act's protections.	The departments seek comment on this approach.	
Interactions with State Law	State surprise billing laws that apply to state-regulated plans (and ERISA self-funded plans in states that allow those plans to opt in to the state's processes) supersede the protections in the IFR.		
Determination of Payment Amount to Providers and Facilities	The total amount the plan must pay to the out-of-network provider for services subject to the act's protections, is based on the following minus any patient cost-sharing obligations: • An amount determined by a state All-Payer Model Agreement under Section 1115. • An amount determined by a specified state law that applies to the particular service, payer and provider. • In the absence of an All-Payer Model Agreement or state law, a payer/provider agreed-upon amount. If none of these conditions apply, the amount is determined through IDR.	The departments seek comment on the impact this change will have on out-of-network providers and plans.	

Determination of Enrollee's Cost-Sharing Amount	Cost-sharing is based on the "recognized amount", which is one of the following: • An amount determined by a state All-Payer Model Agreement under Section 1115. • An amount determined by a specified state law that applies to the particular service, payer and provider. • In the absence of an All-Payer Model Agreement or state law, the lesser of the billed charge or the plan's median contracted rate – the "qualifying payment amount" (QPA).	The departments seek comment on the impact of these provisions on services, coverage and payment for and within medically underserved, rural, and urban communities.	
Methodology for Calculating the QPA	The QPA is defined as the issuer's median in-network rate for 2019 trended forward[1] and is based on: • The median of at least three contracted rates recognized by the plan on Jan. 31, 2019, for the same or similar item or service that is 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. • The determination of the median contracted rate is based on all group or individual health plans of the issuer (or administering entity) in the same insurance market. • The issuer must first arrange the contracted rates based on their amounts and then select the middle number of those rates. If there are an even number of contracted rates, the median is the average of the middle two contracted rates. o Each amount negotiated under each contract is treated as a separate amount. o If the same amount is paid under two or more separate contracts, each contract is counted separately. • To calculate the median contracted rate for items and services furnished in 2022, plans will use rates as of Jan. 31, 2019, increased by CPI-U for each of 2020 and 2021. The 2022 rate will then be adjusted annually for 2023 and subsequent years. • For the years after 2019, plans must have at least three contracted rates for the prior year that account for at least 25% of that year's total claims volume for the relevant item or service for all plans in the same insurance market.	The departments seek comment on all aspects of this methodology, including: • The impact of the methodology on cost-sharing, payment amounts and provider network participation. • Whether there are areas where additional rulemaking or guidance is necessary.	Please provide feedback regarding this methodology, including any potential impact on future contracting.

[1] The median in-network rate will also be considered during any IDR process to adjudicate plan/provider payment disputes under the act.

Determining the Median Contracted Rate **Definition of "Contracted Rate"**	The IFR defines "contracted rate" as the total amount (including cost-sharing) that a plan has contractually agreed to pay an in-network provider for covered items and services, whether directly or indirectly, including through a third-party administrator or pharmacy benefit manager. • Single case agreements do not constitute contracts. When calculating the QPA, plans: • Must treat a rate as a single rate when it applies to all providers of a group or facility under a single contract, regardless of the number of claims paid at that rate. • Must treat each unique contracted rate as a single contracted rate when it has separate contracts and negotiated rates with each of multiple providers for a given item or service.		
Determining the Median Contracted Rate **Definition of "Insurance Market"**	The IFR defines "insurance market" as the individual, small group or large group market, irrespective of state. • For self-insured plans, the insurance market is all self-insured group health plans of the plan sponsor or the same administering entity (including a third-party administrator).		
Determining the Median Contracted Rate **Definition of "Same or Similar Item or Service"**	The IFR defines "same or similar item or service" as a health care item or service billed under the same service code (i.e., CPT, HCPCS or DRG code), or a comparable code under a different procedural code system, including any modifiers. • To distinguish between provider and facility median contracted rates, plans must calculate separate median contracted rates for CPT code modifiers that distinguish the professional services component ("26") from the technical component ("TC").		Please provide feedback on this proposed definition.
Determining the Median Contracted Rate **Definition of "Provider in the Same or Similar Specialty"**	The IFR defines "provider in the same or similar specialty" as the practice specialty of a provider, as identified by the plan consistent with the plan's usual contracting practices. • Median contracted rates must be calculated separately for each specialty if rates for a service code vary based on specialty.		Please provide feedback on this proposed definition.

Determining the Median Contracted Rate **Definition of "Same or Similar Type of Facility"**	The IFR requires a separate median rate calculation for each facility type only if a plan varies its contracted rates for emergency services based on the type of facility (e.g., an emergency department of a hospital or an independent freestanding emergency department). There is no separate calculation of a median contracted rate based on other characteristics of facilities that might cause contracted rates to vary, such as whether a hospital is an academic medical center or teaching hospital.	The departments seek comment on this approach, including whether it would be more appropriate for plans to always or never calculate separate QPAs for hospital emergency and independent freestanding emergency departments.	Please provide feedback on this proposed definition.
Determining the Median Contracted Rate **Definition of "Geographic Services"**	The IFR defines "geographic services" as one region for each metropolitan statistical area (MSA) in a state and one region consisting of all other portions of the state. MSAs that cross state boundaries are divided between their respective states and counted in each state as a geographic region. When there is insufficient information to calculate the median contracted rate in an MSA: • All MSAs in the state will be a single region and all other portions of the state will constitute a different region. • Geographic regions will be based on the nine Census divisions if there still is not enough information, with one region consisting of all MSAs in the division and one consisting of all other portions of the division.		
Determining the Median Contracted Rate for Non-fee-for-service Rates	Plans must use underlying fee schedules, when available, to calculate the median contracted rate when a fee schedule is used to determine cost-sharing under non-fee-for-service contracts. • If there is no underlying fee schedule, plans must use the price it assigns to an item of service for internal accounting and reconciliation with providers. • Plan's calculations of the median contracted rate must exclude risk-sharing, bonus, or other incentive payments.		
Determining the Median Contracted Rate for Unit-based Services	When plans determine reimbursement by multiplying the contracted rate by another unit, such as time or mileage, they must apply those multipliers after determining the median contracted rate for the base unit.		

Determining the Median Contracted Rate with Insufficient Information	When the plan lacks sufficient information to calculate the 2019 median contracted rate, it may use a third-party database. Eligible databases include state all-payer claims databases and others maintained by organizations not affiliated with any insurer or provider. • The database must have sufficient information reflecting in-network payment amounts for relevant items or services in the geographic area. The IFR does not define "sufficient information." • Using the database, payers will determine a median contracted rate based on the in-network allowed amounts for items and services by all private payers in the geographic region, indexed for inflation. • Payers must use the same database and method for a particular item or service throughout a calendar year. When a plan must determine a median contracted rate for a service code created or substantially revised after 2019, it must identify a "reasonably related" code from the preceding year and adjust it based on the ratio between the Medicare rate for that new code and the related code.	The departments seek comment on: • How to define when a database has sufficient information, such as a requirement that the database represent a specified minimum percentage of the claims volume for the region. • Whether additional rules are needed regarding how plans identify a reasonably related service code • Whether any more specific requirements are needed to determine the relativity ratio.	Please provide feedback on this approach.
Plan Disclosures to Providers Regarding the QPA	Plans must make the following disclosures to the out-of-network provider with each initial payment or notice of payment denial. • The QPA for each item or service involved and a statement certifying that the QPA is the recognized amount (for purposes of patient cost-sharing) and was calculated in compliance with the IFR methodology. • A statement confirming the option for a 30-day open negotiation period to determine the total payment amount followed by initiation of IDR within 4 days of the end of the open negotiation period. Providers may request additional information from the payer.	The departments seek comment on: • Additional information a plan must share with a provider about the QPA, either in all cases or upon request. • Whether a specific definition or standard is needed to ensure plan's timely disclosure of information in response to a provider request.	

Notice and Consent	The act's protections do not apply if notice is given and consent received from the patient in relation to certain post-stabilization and non-emergency services. Providers may not seek consent when: • There is no participating provider (physician or non-physician practitioner) who can furnish an ancillary service, including emergency medicine, anesthesiology, pathology, radiology, and neonatology; items and services provided by assistant surgeons, hospitalists, and intensivists; and diagnostic services, including radiology and laboratory services. • Additional items or services are furnished in response to unforeseen, urgent medical needs. Primary care providers do not need to provide notices.		
Providers' Notice Requirements	Providers must post a standard notice[2] of patient's rights under the act on a public website and prominently in a publicly accessible location in their facility, such as where patients schedule care, check-in, or pay bills. Providers must also give the notice, along with a consent form to waive the act's protections, to patients at least 72 hours before the non-emergency service is to be delivered. When a same day service or treatment is provided, the notice and consent forms must be provided no later than three hours before receipt of the item or service. Providers must use the standard written consent form[3] created by HHS, tailored to each individual patient. The notice and consent forms must: • Be given to the patient separately from other documents. • Be in plain language. • Be available in any of the 15 most common languages in the geographic region in which the applicable facility is located. o Providers must furnish a qualified interpreter when an individual's preferred language is not among the 15 most common languages or the individual cannot understand the language in which the documents are provided. • Include information about the Act's protections, any state requirements, and how to contact state and federal agencies regarding potential violations. The tailored consent form also must include:	The departments seek comment on: o Whether the 3-hour time limit should be longer or shorter to ensure that consent is freely given while also facilitating timely access to care. o Whether the timing presents barriers to providers' ability to comply. o Potential challenges facilities may have coordinating the development of a good faith estimate on behalf of individual providers. o The method by which the good faith estimate should be calculated for consideration in future rulemaking. o Whether the provider should be required to	Please describe any challenges your hospital may face or concerns you have regarding any of these requirements.

[2] Go to "CMS-10780" on the CMS webpage for the standard notice and consent forms. HHS is accepting comments on the forms until Aug. 12.
[3] See above.

	• A list of in-network providers at the facility.
	• Information about prior authorization or other care management limitations.
	• A good faith estimate that reflects the amount the provider expects to charge for the out-of-network items or services, even if the provider or facility intends to first bill the plan.
	  o The estimate must include a disclaimer that it does not constitute a contract.
	  o The specific process to develop the good faith estimate and related requirements will be address in future rulemaking.
	
	If a patient signs a consent form, their provider must:
	• Notify their plan in a timely fashion that the Act's protections do not apply to the item or service.
	• Provide a signed copy of the notice and consent documents to the plan.
	• Retain written notice and consent documents for at least a 7-year period.
	• Provide the patient or authorized representative with a copy of the signed notice and consent in a form of their choosing (paper or electronic).
		include in the notice information about the individual's plan coverage, an estimate of the individual's out-of-pocket costs, and specific information about any related prior authorization and care management requirements.
		
		Barriers or other burdens to obtaining any of the required notice information from a plan.	

Notice Requirements for Plans	Plans must post information about balance billing and cost-sharing protections on their website and include information on each explanation of benefits for each item or service.		
Initial Payments or Notice of Payment Denial	Plans must send an initial payment or notice of denial of payment no later than 30 calendar days after receiving a clean claim from an out-of-network provider related to the items and services that fall within the scope of the Act. • "Initial payment" is the amount the plan intends as payment in full based on relevant facts and as required under the plan terms prior to open negotiation or IDR.[4] • The IFR preamble notes that plans are expected to act "reasonably and in good faith" when requesting additional information about a claim from a provider and may specify additional standards if plans are shown to be unduly delaying initial payments. Plans must process clean claims based on existing ERISA timelines, with the exception of the timeline to process additional information subsequent to an initial payment denial. In those situations, plans must send a payment denial or	The departments solicit comment on: • Whether any additional standards are necessary to prevent abusive claims payment practices. • Whether to set a minimum payment rate or methodology for a minimum initial payment in future rulemaking. The following examples are provided for comment:	Please describe any current challenges you may face with claims payment practices by commercial payers, as well as your feedback on the establishment of a required minimum payment rate methodology.

[4] Some states have a minimum initial payment amount, such as Washington, which would supersede this requirement.

	initial payment within 30 calendar days (rather than 15 days as required under ERISA) from the time the claim is resubmitted when the following conditions are met: • The adjudication of the claim will not affect the amount the enrollee owes. • The dispute only involves payment amounts due from the plan to the provider. • The provider has no recourse against enrollee, the decision is not an adverse benefit determination and the payment dispute may be resolved through the open negotiation or IDR.	○ a specific percentage of the Medicare rate. ○ a specific percentage of the plan QPA for the item or service. ○ an amount calculated in the same way the plan typically calculates payment for the specific item or service to out-of-network providers. ○ an amount representing the highest amount that would result from applying two or more of these or other methodologies. ○ another method. • Whether a minimum payment rate should be defined as a commercially reasonable rate based on payments for the same or similar services in a similar area, without requiring any specific methodology. • The impact of these provisions on underserved and rural communities, and other communities facing a shortage of providers.	
Consumer Complaints	HHS will receive balance billing consumer complaints directly and respond within 60 days with an explanation of the process and a request for more information as necessary. • There is no deadline by which complaints must be filed. • Responses from HHS could include a referral back to a state agency for resolution.		

HHS Enforcement	Future rulemaking will address detailed enforcement requirements related to providers and plans. The IFR notes that existing enforcement procedures apply related to plan compliance with the QPA calculation methodology. The act authorizes HHS to impose civil money penalties on providers that violate the Act's protections. • Providers could be subject to civil monetary penalties of up to $10,000 per violation, unless the provider unknowingly committed the violation, withdraws the bill and reimburses the patient within 30 days of the violation.		