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HHS Issues Second Set of Regulations Implementing the No Surprises Act

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On September 30, U.S. Departments of Health and Human Services (HHS), Labor, and Treasury, as well as the Office of Personnel Management, issued another interim final rule — "Requirements Related to Surprise Billing: Part II" — implementing certain provisions of the No Surprises Act (Act) and requesting stakeholder comments on several issues, including the federal independent dispute resolution (IDR or Federal IDR) process to determine the reimbursement rate for out-of-network services under certain circumstances.[1] We previously issued a client alert summarizing Part I of the interim final rule issued on July 1.

In general, this interim rule provides additional protections against surprise medical billing by:[2]

- Establishing an independent dispute resolution process to determine out-of-network payment amounts, within 30 business days, between providers (including air ambulance providers) or facilities and health plans for items and services that are emergency services, nonemergency services furnished by nonparticipating providers at participating facilities, and air ambulance services furnished by nonparticipating providers of air ambulance services (the "Federal IDR");

- Requiring health care providers and facilities to provide good faith estimates of medical items or services for uninsured (or self-paying) individuals upon their request and at the time of scheduling the item or service;

- Establishing a patient-provider dispute resolution process for uninsured (or self-paying) individuals to determine payment amounts owed to a provider or facility when receiving emergency care, or nonemergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers; and

- Providing a way for consumers with health insurance to appeal or dispute whether their health plan's denial complies with the new surprise billing and cost-sharing protections to an independent dispute resolution entity.

The Federal IDR process can be initiated by a payor or provider in the event of a dispute related to payments for out-of-network emergency services, certain nonemergency items, or services furnished by nonparticipating providers at participating facilities and air ambulance services furnished by nonparticipating providers of air ambulance services[3] The disputing party must first initiate a "30-business-day"[4] open negotiation period to determine the out-of-network rate.[5] This open negotiation period occurs without the involvement of the departments or a certified IDR entity.[6]

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If the open negotiation process fails, either party may then initiate the Federal IDR process.[7] The initiating party must indicate its preferred IDR entity upon initiation, and the non-initiating party must object or agree to the selection within three business days. In the event the parties do not agree on an IDR entity, the departments will select the entity.[8]

Once the IDR entity is selected, both the payor and provider must submit the amount they believe the service should cost and provide supporting documentation.[9] The IDR entity will then issue a binding determination, not later than 30 business days, selecting the party's offer that best represents the appropriate out-of-network rate for the qualified IDR items or services.[10] The IDR entity begins with the presumption that the qualifying payment amount (QPA)[11] (*i.e.,* the plan's median contracted rate) is the appropriate out-of-network amount. A party, however, may submit additional information allowed under the statute, which the IDR entity will review and determine for credibility and whether it clearly demonstrates that the value of the item or service is materially different from the QPA.

The interim rule also describes the certification process for IDR entities. IDR entities must demonstrate "sufficient arbitration and claims administration of health care services, managed care, billing, coding, medical, and legal expertise."[12] They must also employ sufficient personnel to make determinations within the 30 business days allowed.[13] IDR entities must further ensure that no conflicts of interest exist. They must also comply with confidentiality standards similar to the requirements found under HIPAA and the HITECH Act and comply with 9816(c)(4)(A)(v), ERISA Section 716(c)(4)(A)(v), and PHS Act Section 2799A-1(c)(4)(A)(v).[14]

The interim rule's fact sheet also provides that health care providers and facilities are required to give uninsured (or self-paying) individuals "good-faith estimates of expected charges for scheduled health care services, and may have to participate in a patient-provider payment dispute resolution process if their billed charges are higher than the good-faith estimates."[15] These services include any item or service that is reasonably expected to be provided in conjunction with such scheduled or requested item or service reasonably expected to be provided by another provider or facility.[16] For 2022, though, providers will not be penalized for good faith estimates that do not "include expected charges from other providers and facilities that are involved in the individual's care."[17]

The agencies are again inviting comments for 60 days, following publication in the *Federal Register*.[18] Some specific topics on which the agencies have requested comment include:[19]

- Appropriate data transfer standards between providers and facilities and plans and issuers;
- Enforcement actions for failure to provide a good faith estimate to individuals not enrolled in a plan or coverage, and if the estimates should be expanded to include additional information and expected charges for items or services that are anticipated to be provided prior to or following the period of care;
- Additional or alternative supports for individuals with limited English proficiency or those with disabilities who require information in alternative and accessible formats.

There is some concern among stakeholders, however, that more time is needed to implement the new dispute resolution process — currently scheduled for January 1, 2022.[20] Troutman Pepper will continue to monitor the

No Surprises Act and provide updates when more guidelines are released.

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[1] *See* https://www.cms.gov/files/document/cms-9908-ifc-surprise-billing-part-2.pdf.

[2] *See* https://www.cms.gov/nosurprises/Policies-and-Resources/Overview-of-rules-fact-sheets.

[3] *See* https://www.cms.gov/files/document/cms-9908-ifc-surprise-billing-part-2.pdf.

[4] The 30-business-day period is to begin on the day either party receives an initial payment or a notice of denial of payment for an item or service. *See Id*.

[5] The interim rules provide for this arbitration process to "an emergency service, a nonemergency item or service furnished by a nonparticipating provider at a participating facility subject to the surprise billing protections for which the notice and consent exceptions do not apply, and for which the out-of-network rate is not determined by reference to an All-Payer Model Agreement … or as specified state law." *See* https://www.troutman.com/insights/hhs-issues-interim-final-rule-for-the-no-surprises-act.html; *see also* https://www.fiercehealthcare.com/hospitals/biden-admin-releases-surprise-billing-rule-detailing-arbitration-process.

[6] *See* https://www.cms.gov/files/document/cms-9908-ifc-surprise-billing-part-2.pdf.

[7] *Id*.

[8] *See* https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii.

[9] *See* https://www.fiercehealthcare.com/hospitals/biden-admin-releases-surprise-billing-rule-detailing-arbitration-process.

[10] *Id*.; *see also* https://www.cms.gov/files/document/cms-9908-ifc-surprise-billing-part-2.pdf.

[11] The No Surprises Act first introduced "QPA," which is defined as the "plan's median contracted rate — the middle amount in an ascending or descending list of contracted rates, adjusted for market consumer price index in urban area (CPIU)." In adjusting by the consumer price index, the QPA attempts to minimize the influence of high outlier rates. *See* https://www.multiplan.us/what-is-qpa/#:~:text=The No Surprises Act introduces,in urban areas (CPIU).

[12] *See* https://www.cms.gov/files/document/cms-9908-ifc-surprise-billing-part-2.pdf.

[13] *Id*.

[14] *See* 26 CFR 54.9816-8T(e)(2)(v), 29 CFR 2590.716-8(e)(2)(v), and 45 CFR 149.510(e)(2)(v); *see also* https://www.cms.gov/files/document/cms-9908-ifc-surprise-billing-part-2.pdf.

[15] *See* https://www.cms.gov/nosurprises/Policies-and-Resources/Overview-of-rules-fact-sheets.

[16] *See* https://www.cms.gov/files/document/cms-9908-ifc-surprise-billing-part-2.pdf.

[17] *See* https://www.fiercehealthcare.com/hospitals/biden-admin-releases-surprise-billing-rule-detailing-arbitration-process.

[18] *See* https://www.federalregister.gov/public-inspection/2021-21441/requirements-related-to-surprise-billing-part-ii.

[19] *See* https://www.cms.gov/files/document/cms-9908-ifc-surprise-billing-part-2.pdf.

[20] *See* https://apnews.com/article/business-health-5d91f6349753e1e8f21633ad55d12c61.

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