Centers for Medicare & Medicaid Services

National Stakeholder Call on the Requirements Related to Surprise Billing Part 1,

An Interim Final Rule

July 22, 2021

3:30 pm ET

Coordinator: Welcome and thank you for standing by. At this time all participants are in listen-only mode until the question and answer session of today's conference. At that time you may press Star 1 on your phone to ask a question.

Today's conference is being recorded. If you have any objections, you may disconnect at this time. I will now turn the conference over to Dr. Gene Freund. Thank you. You may begin.

Dr. Gene Freund: Thanks (Terry). Good afternoon and welcome to the National Stakeholder call on the Requirements Related to Surprise Billing Part 1, an Interim Final Rule. I'm Dr. Gene Freund, Medical Officer in the Partner Relations Group in the CMS Office of Communications and I'll be moderating today's listening session.

Today I'm joined by a number of my amazing colleagues at the CMS Center for Consumer Information and Insurance Oversight or CCIIO. But before we begin I have a few housekeeping tips.

This call is informational only and not intended for the press. While members of the press are welcome to attend the call please note that all press media questions should be submitted using our Media Inquiries Form which we can - can be found at the newsroom at cms dot gov or by emailing press@cms.hhs.gov.

Today's listening session is an opportunity for stakeholders to ask questions related to the requirements related to surprise billing Part 1 Interim Final Rule. I'm repeating myself. But official comments should be submitted to regulations.gov. And if you go to regulations.gov I found that using the search tool in the Web site searching on surprise billing finds that really well rather than reading the long address. (Dave Mlawsky), from CCIIO will begin. Go ahead, Mr. Mlawsky

(Dave Mlawsky): Thank you Gene. On July 1, Health and Human Services along with the Departments of Labor and Treasury and also the Office of Personnel Management issued interim final rules to implement key provisions of the No Surprises Act, which was bipartisan legislation enacted in December of last year to protect patients with private health coverage from surprise medical bills. And I'll point out that neither the legislation nor the regulations prohibit balance billing in all circumstances just circumstances where it most likely might be a surprise to enrollees in health plans and health insurance.

In addition to the interim final rule we also released two separate documents that correlate to provisions in the statute and the rule. One is a standard notice and consent form for providers and facilities to use in very limited situations to ask individuals if they'd like to waive their balance billing protections. Again in very limited circumstances where the statute and regulations permit that.

The second document was a model disclosure notice to inform individuals about their rights and protections regarding balance billing which is a notice that providers, facilities, issuers and plans have to disseminate. And this regulation that we just published talks about that requirement as it applies to providers and facilities. And the statute itself as I mentioned applies to all four of those of those entities.

The final rule that we issued, the interim final rule, is the first in a series of rules to implement the No Surprises Act. This particular rule, the one issued July 1, implements a number of important consumer protections that apply to group health plans, health insurance issuers, health care providers and facilities and also air ambulance providers beginning on January 1, 2022.

Now there are additional provisions in the No Surprises Act that this particular rule does not cover. That will be the subject of additional rulemaking. One is the No Surprises Act establishes two separate independent dispute resolution processes to resolve payment disputes.

One of those processes is to resolve disputes between health plans and out of network providers. And the other process is to resolve disputes between providers and uninsured individuals who get a estimate for, a cost estimate for care and when they get billed that estimate is significantly more than what was estimated. And we expect to issue, start issuing those additional rules fairly soon.

So just by way of background the No Surprises Act establishes really the first comprehensive federal protections against balance billing for the private market. There have been some existing state protections but the No Surprises Act for the first time introduces some comprehensive federal protections. And patients will be protected from balance bills in three contexts. And as I mentioned before those are contexts where balance bills are most likely to be - to come as a surprise for consumers.

The first scenario is when receiving emergency services from an out of network provider or emergency facility including post stabilization services. The second scenario is when an individual receives non-emergency services

from an out of network provider at certain in network facilities. And those facilities would include hospitals, hospital outpatient departments and surgical - and of course surgical centers. And third scenario is when receiving out-of-network network air ambulance services.

And as I said these protections go into effect beginning January 1, 2022. And it will apply to consumers who are enrolled in most types of private health coverage including employer sponsored plans from both, you know, private and public employers, individual health insurance coverage offered through or outside the marketplace, and also FEHBP plans which are the plans that cover federal employees.

So the rule protects individuals from surprise billings, from surprise bills in a number of different ways. It limits cost sharing for out of network services to in network levels. It requires cost sharing to be counted toward a patient's in-network deductible and annual out-of-pocket maximums. And it also prohibits providers and facilities from sending balance bills to patients or otherwise holding them liable for cost sharing beyond what they would have paid for in-network care.

The rule describes how cost sharing for these services is based on a term used in the statute known as the recognized amount. And the rule also includes a discussion and examples of when a specified state law rather than the specific provisions in the No Surprises Act will apply to determine the cost sharing and out-of-network rate. And a specified state law is a law that provides a method for determining the total amount payable to an out-of-network provider by the plan or issuer.

The interim final rule also includes a detailed methodology that will be used to calculate again, a term used in the statute, the qualified payment amount

which is the plan's or issuer's median contracted rate for the same or similar item or service provided in a geographic region. And generally that will be the amount that is used to determine the individuals cost sharing in instances where they get out-of-network care that's covered by the No Surprises Act in the regulations.

In terms of how the QPA, or Qualifying Payment Amount is determined, these rules provide a process to determine the QPA when a plan or issuer doesn't have sufficient information to calculate a median contracted rate. And it also addresses the information that plans and issuers must share about the QPA calculation with the provider or facility which again is very important because the cost sharing is based on that in most cases so the provider or facility kind of needs to know what the QPA is so it can apply the right, for example, coinsurance amount to the - for the patient.

As I mentioned before, in very limited circumstances a patient can consent to waive the balance billing protections in the No Surprises Act in the regulations and receive care on an out-of-network basis and be balance billed for it. And this applies with respect to post stabilization services meaning services that are provided following emergency care as well as to non-emergency services.

The interim final rule includes a number of different provisions that are intended to protect consumers with respect to the notice and consent and to make sure that the notice and consent is legitimate and provided freely. I'll mention a few examples, the notice has to be provided in the 15 most common languages in the geographic region in which the applicable facility is located. And in addition, the interim final rule includes additional protections for when an individual cannot understand one of those 15 languages.

The rule does allow an individual's authorized representative to see the notice and provide consent on behalf of the patient. However, the rules include important protections to ensure that the authorized representative is acting on behalf of the individual and not the facility or the provider. So that's very important.

Also, the notice and consent has to be provided a specified period of time prior to the furnishing of the services. And generally, these timing requirements align with those that are specified in the statute. However, the rule has a requirement that when notice and consent is provided on the same day as items or services are provided, consent must be provided at least three hours prior to the service being furnished. And this is in response to concerns that we've heard from consumer advocates about whether consent is really freely given if it's sought and given like immediately prior to the furnishing of the services.

Now for people receiving post stabilization care there are some kind of additional parameters or protections for individuals with regard to the notice of consent. As, you know, you would expect people who just received emergency care are typically in a physical and/or mental condition that perhaps might make them more vulnerable to giving consent when they might not otherwise would.

So for example the individual has to be able to travel using nonmedical transportation or non-emergency medical transportation to an available participating provider or facility located within a reasonable travel distance taking into account the individual's medical condition. Also the attending emergency physician or treating provider must determine that the individual or their authorized representative is in a condition to receive the written notice and provide informed consent under state law.

And that's again very important to ensure that these, you know, vulnerable individuals to the extent that they're asked to provide consent and are giving consent are doing so freely and in a way that is not compromised by the condition, mental or physical, that they may be in. Consent has to be provided voluntarily without undue influence from duress.

Finally, providers and facilities will be required to use a standard format specified by HHS on the notice and consent forms. And as I mentioned before we've published in conjunction with the regs a standard form for - and we put that out there for public comment. And I'll mention that we developed that standard form with feedback from user testing.

In addition, the statute and the regulations establishes a complaints process for individuals and organizations to send complaints to the federal government and other regulatory bodies regarding violations or potential violations of the No Surprises Act. And importantly the rule establishes what we call a no wrong door approach for consumers and others to file complaints about potential violations.

And when I say no wrong door I mean as you probably know different federal agencies and different state agencies kind of share jurisdiction for the provisions in the statute kind of in the same way that that holds true for the Affordable Care Act.

And so essentially if an individual or organization, , regardless of whether it's a provider, a facility, or air ambulance or, whatever type of entity makes a complaint and about whatever type of entity they're making the complaint about when the complaint comes in to a given state or federal agency it will be

kind of channeled to the correct one, so the individual making the complaint won't have to kind of hunt for the correct place to make their complaint.

There's also provisions here that I mentioned before, disclosure requirements. The rule, along with the statute, requires providers and facilities to provide patients with easily understandable notice regarding the patient protections against balance billing and how to contact the appropriate state or federal agency for violations of the No Surprises Act.

And the notice itself has to provide information not only about federal protections against surprise billing but also any applicable state protections. And so that's another very important point. And as I said before we've released a model disclosure notice that can be used by plans, issuers, providers and facilities to satisfy that disclosure requirement. So the regulations are generally applicable for plan years beginning on or after January 1, 2022. And they're applicable to providers and facilities beginning on January 1, 2022 as well.

This is an interim final rule so we're soliciting comments on it. And written comments can be submitted on the rule as well as on related materials those two other documents that I just mentioned. Comments on the rule itself must be submitted by 5:00 pm on September 7. And comments on the notice and consent form and the model disclosure notice are due 30 days after publication which means the comments will be due by August 12.

So that concludes my formal presentation, overview of the law and the regulations. And I guess we can now open it up for questions.

Dr. Gene Freund: Thank you (Dave). Operator, go ahead.

Coordinator: So thank you. If you would like to ask a question please press Star 1. If you need to withdraw your question press Star 2. Again to ask a question please press Star 1. And it will take a few moments for questions to come through so please stand by. And our first question comes from (Carlene Dietrich). And your line is now open.

(Carlene Dietrich): Yes. How does the interim final rule apply to insurance companies that send checks directly to the patient because the providers have to bill those patients or bill charges when they don't receive payment from the insurance company? I don't see that that's being addressed in the final rule.

Lindsey Murtagh: Hi. This is Lindsey Murtagh from CCIIO. So when these balance billing protections apply providers need context from billing the patient anything more than the amount of cost sharing that is allowed under the statute. And so these rules reflect the approach taken in the statute that Congress passed which means that in these circumstances a provider would not be allowed to send a bill to the patient for the full charge they would need to be working directly with the insurance company.

Coordinator: Thank you. And our next question comes from (Michael Brissman). And your line is now open.

(Michael Brissman): Hi. Thank you. A quick question in determining the QPA you mentioned that you're calculating by the number of contracts not by the number of times that amount is paid. But I wanted to understand are those contracts only those contracts with entities that use that use that code or with any contract?

For example, let's say Blue Cross has 100 contracts with ophthalmologists where they pay the ophthalmologist two times Medicare for ophthalmology rates but orthopedic rates and all other rates paid in Medicare rates would

those 100 contracts be counted towards calculating the orthopedic rate or would the orthopedic rates only be determined by contracts with hospitals or entities that actually bill orthopedic rates because otherwise the QPA is just going to be Medicare.

(Dave Mlawsky): Right, I can start taking this one. The QPA would be determined by contracts that the commercial issuer, or the commercial side of the house, has with that specialty or that type of provider. Does that answer your question?

Coordinator: Thank you. And our next question comes from (Larry Tate). And your line is now open.

(Larry Tate): Thank you. We've seen a reference in here to radiology services being germane to this regulation. Our question is, if we have out of network radiation oncology providers providing services to patients in a hospital that is in-network with the insurer is that applicable to this regulation that radiation oncology would fall under it?

((Crosstalk))

(Dave Mlawsky): Go ahead Lindsey, I'm sorry.

Lindsey Murtagh: Oh, so I was just going to say, and (Dave) you should add on, is I think you're talking about the non-emergency setting. And so that applies any time somebody is receiving non-emergency services in a participating facility from a non-participating provider so that there are no limitations on which - what type of provider that may be.

There are some, you know, additional kind of requirements and instructions related to the notice and consent (Dave) was discussing. And in that context I

believe -- and (Dave) keep my honest -- the radiologists are included under the statute as an ancillary service provider but let me confirm that. I'll ask (Dave) you can confirm it right now. And the statute does not distinguish between types of radiology.

(Dave Mlawsky): I believe that's right.

Lindsey Murtagh: Yes.

Coordinator: Thank you. And our next question comes from (Vincent Chen). And your line is now open.

(Vincent Chen): Yes. I was going to ask where the recording will be available for replay and also what are the status for those additional rules on dispute resolution between insurance companies and providers?

(Dave Mlawsky): The regulations on the dispute resolution process we do expect to be out later this year.

Dr. Gene Freund: And I believe the recording will appear in the Podcast and Transcripts tab on the Open Door Forums page kind of way down at the bottom. Jill Darling will jump in and tell me if I was wrong about that.

Jill Darling: You're correct.

Coordinator: Thank you. And our next question comes from (Ben DeBrunner). And your line is now open.

(Ben DeBrunner): Thank you. I'm hoping you can clarify an understanding that I've gleaned from reading the rule. It appears that cost sharing will be determined according to

2019 qualifying payment amounts that's then trended forward to - for CPIU which I think historically has tended to not keep pace with the increase in medical costs.

Am I understand correctly that cost sharing will increase generally according to CPIU potentially resulting in future scenarios where in-network cost sharing is higher than out-of-network cost sharing because it's been held to 2019 - and then indexed to a nonmedical growth rate?

(Dave Mlawsky): It is tied to the CPIU. Now what the future consequences of that are, that I'll withhold comment on but you are correct in terms of what the regs say.

Lindsey Murtagh: Yes, and I would certainly encourage you to submit comments on that.

Coordinator: Thank you. And our next question comes from (Casey Yarborough). And your line is now open.

(Casey Yarborough): Hi. Good afternoon. Thank you everyone for taking my question. In my state we actually have a balance billing law that details a process for coming up with reimbursement for an out-of-network provider rather than a specified amount. And I was wondering if you had any thoughts on whether or not that is applicable in determining the provider payment for out-of-network services or as the regulations state does that state law to supersede the federal law actually need to have a specific amount for the services that are covered under the balanced billing protections?

(Dave Mlawsky): Right. The - if you have to specified state law that has a process and my colleagues can jump in, but to the extent that process applies, you know, to the plan or issuer, and to the provider or facility, and to the item or service then a

state process would apply as a specified state law. And again I'll invite my colleagues to add anything to that.

Lindsey Murtagh: I think you covered it (Dave).

Coordinator: Thank you. And our next question comes from (Dawn Bododeia). And your line is now open.

(Dawn Bododeia): Thank you. My question I guess it really has to do it like anesthesiologists, doctors and trauma centers, emergency room doctors these are all physicians that are doing things in an emergency situation. And I understand that there needs to be a limit on what they can charge but why isn't more of this being pushed back on the insurance company to pay as opposed to the patient?

So the patient gets the bill, they see a doctor in the ER. His bill is $500 the insurance company paid $100 to the patient because the doctor was out-of-network. Why didn't they have to pay the whole bill? Like we're pushing this all back on the physician who's going to work every day as opposed to the insurance company.

Lindsey Murtagh: (Dave), do you want me to take this one?

(Dave Mlawsky: Yes, I can jump in.

Lindsey Murtagh: Yes. So I think one important thing to note about this rule is that it's the first of a couple of rules. So in this rule we talked about how the cost sharing amount needs to be determined. And what what I think is very interesting about the way the statute and therefore our rule is structured it is they really try to take the consumer out of the middle of any kind of dispute between the

provider or facility and the plan or issuer in terms of what the actual amount is.

So the cost sharing has to be calculated using this process, using what's called the recognized amount. And in some cases that will be the qualifying payment amount. But then there's a separate process for determining what the amount is that is actually paid from the plan or issuer to the provider or facility. And this really talks about it at just a high level.

There's a requirement that the plan has to make either an initial payment or notify the provider or facility within 30 days that they are not making a payment even though they consider it a covered service. And then, once that happens that can open a period of, sorry I shouldn't should say open a period, open and negotiate - it can trigger an open negotiation period during which time the parties can come to some agreement on what the payment should be.

And I'm sorry I should have specified this is in the context of the federal provisions applying so there is not an all payer model agreement or state law that sets out-of-network rates. So in this context there's an opportunity for the parties to negotiate and if they can't reach an agreement there then they end up going - they can go to the - a dispute resolution process which we'll address in the future rule.

So I don't think it's quite accurate to say that this sort of puts it all on the provider. What it does is it takes the individual out of the picture. And so they have their cost sharing that's set at this - through this process using the recognized amount and then the parties end up negotiating. And the way that the law works is it sets up a process through which they can do that.

Coordinator: Thank you. And do we have time for an additional question?

Dr. Gene Freund: I think that's okay as a last question.

Coordinator: Okay. So our final question comes from (Tom Watson). And your line is now open.

(Tom Watson): Thank you very much. I was just wondering if there's going to be a database by CA code for the reasonable value of services provided by health care practitioners that can be used for analysis?

(Dave Mlawsky): A database for what purpose?

(Tom Watson): Well often we have experts who are trying to determine the fair market value of medical services in tort litigation where lien providers are providing a bill amount for taking care of an injured plaintiff.

And that bill often represents, according to experts, anywhere from five to 30 times the fair market value of those services for, you know, a back surgery or knee surgery or something and it's a way to inflate tort damages. So having a database of what is the amounts typically paid and accepted as payment in full for services would help to analyze what is the fair market value of the services?

Lindsey Murtagh: Yes.

(Dave Mlawsky): Right, right. Lindsey, I - were you about ready to...

Lindsey Murtagh: Sure. I was just going to say that this rule does not get at that issue. We - it doesn't require any sort of creation of a database. But I would note that the - this rule is based off of consolidated - codifies the Consolidated

Appropriations Act which did include a number of provisions really aimed at increasing transparency in the health care system related to health care pricing. And so we do expect to continue the work in that area. I can't really speak to your particular question but I think that increasing transparency generally is very consistent with the goals of the statute and where we'd be moving.

(Dave Mlawsky): I'll also mention that in several places in the statute there are requirements for providers and facilities to provide good faith estimates of costs either when a service is scheduled or upon request. So to the extent that a provider or facility is charging exorbitant rates this will - these provisions will give consumers the opportunity to figure that out pretty quickly when they compare those rates to other estimates that they may be getting.

Coordinator: Thank you. We still have multiple questions in queue did you want to go ahead and wrap up now?

Dr. Gene Freund: I think we need to stick to time. So yes I think we do have to do that. There are - you can either based on the rule their contact information there or you could send questions to partnership@cms.hhs.gov. And I really, even though we have to finish to stay on time, I really want to stress the importance of commenting at regulations.gov. And those comments are due by September 7. This ends the discussion. Thanks again for attending.

Coordinator: Thank you. And that concludes today's conference. Thank you for participating. You may disconnect at this time. Speakers, please allow a moment of silence and stand by for your post conference.

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