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HEALTHCARE

Interim Final Rule titled, "*Requirements Related to Surprise Billing; Part I*"
(Rulemaking associated with the No Surprises Act, H.R. 3630, signed into law on December 27, 2020 as part of the Consolidated Appropriations Act of 2021)

Date Released:	July 1, 2021 – The Interim Rule (411 pages) can be viewed at https://www.cms.gov/files/document/cms-9909-ifc-surprise-billing-disclaimer-50.pdf, and a brief summary from CMS is available here.
Comment Period Ends:	August 31, 2021 – Comments can be submitted at https://www.regulations.gov by referencing file code CMS-9909-IFC
Effective Date of Final Rule:	January 1, 2022
Applies To:	Commercial and marketplace plans. Programs such as Medicare and Medicaid have alternative regulations in place prohibiting balance billing. This rule does not apply to healthcare sharing ministries.
Key Provisions:	Emergency Services – covered as if in network*, including air ambulance (but not ground ambulance, given that these services are often managed by local governments) and all necessary post-stabilization services (inpatient or observation). Urgent Care services are not covered under this rule; however, CMS is seeking comments regarding possible inclusion. Payor cannot retrospectively limit coverage for emergency services to certain diagnosis codes, but must instead apply a "prudent layperson" standard to the patient's decision to seek emergency care. Non-Emergent Services – services performed by out of network providers within an in network facility are covered as if in network* unless notice and consent requirements are met that would allow these out of network providers to balance bill. These notice and consent requirements include: determining the patient's capacity to consent, consent given at least 72 hours before date of service (3 hours before same-day appointments) at the same time the patient provides informed consent to undergo the procedure itself, and the notice must include a good-faith estimate of costs. Certain providers (radiologists, hospitalists, intensivists, etc.) and situations (where no in-network specialist alternative is available, services that result from unforeseen urgent medical needs, etc.) are not allowed to balance bill through this notice and consent process.

Key Provisions: (continued)

State Surprise Billing Laws may supersede this Interim Rule in certain circumstances.

Provider Disclosure – notice of protections against balance billing must be published on the hospital's website and provided to patients.

***Covered as if in network*:**

- Unless state law or an all-payor agreement governs, the in network cost sharing amount is the qualifying payment amount (QPA), calculated as the plan's median in network rate for the specific service (indexed in subsequent years).
- The payor has 30 days to remit the QPA.
- If the provider finds the QPA to be unacceptable, the provider may initiate a 30-day negotiation period.
- If agreement is not reached at the end of the 30-day negotiating period, the provider has four days to initiate the independent dispute resolution (IDR) process. Each party submits its last best offer, and the IDR entity selects between the two offers (with the loser paying the IDR administrative costs).