799 9th Street NW
Suite 210
Washington, DC 20001

T (202) 354-2600
vizientinc.com

Vizient Office of Public Policy and Government Relations

Office of Personnel Management; Department of the Treasury; Department of Labor; Department of Health and Human Services: Requirements Related to Surprise Billing; Part II

October 19, 2021

Background & Summary

On September 30, 2021, the Office of Personnel Management (OPM), Department of the Treasury (Treasury), Department of Labor (DoL), and Department of Health and Human Services (HHS) (the Departments) issued an interim final rule with comment period, "Requirements Related to Surprise Billing; Part II" (hereinafter "IFC"). The IFC, which is part of a series of other recently released regulations, aims to implement certain provisions of the Consolidated Appropriations Act, 2021 (CAA), related to surprise medical bills (i.e., the No Surprises Act (NSA)). Specifically, the IFC details the Federal Independent Dispute Resolution (IDR) process, good faith estimates for uninsured (or self-pay) individuals and the patient-provider dispute resolution process.

While the Departments released two sets (summaries are available here) of surprise billing regulations earlier this year to implement the NSA, this IFC is the third set of regulations with more anticipated in the future. For clarity, while this most recent regulation is titled "Part II" of the surprise billing regulations throughout, it is still the third set of regulations released. In addition, at the same time this IFC was released, the Centers for Medicare and Medicaid Services (CMS) announced a new No Surprises Act website that provides additional resources about the NSA, including information on payment disagreements.

Comments on the IFC are due December 6, 2021, with the regulations being applicable on January 1, 2022. Since the IFC is an interim final rule, stakeholders should anticipate implementing the IFC as currently drafted.

Federal Independent Dispute Resolution (IDR) for Plans, Issuers, Providers and Facilities

The IFC provides regulations for the Federal IDR process and provides information regarding the interaction of federal and state law.

Open Negotiation

The IFC provides processes for the open negotiations and IDR process that would be utilized when there is a surprise bill and when other circumstances do not exist (e.g., the notice and consent exceptions outlined in prior regulations do not apply and when the out-of-network rate is not determined by reference to an All-Payer Model Agreement or state law). For the Federal IDR process to occur, the open negotiation process must first occur. Any party (i.e., nonparticipating provider, facility, or nonparticipating provider of air ambulance services) may initiate the open negotiation period during a 30-business-day period that starts on the day that the nonparticipating provider or facility receives either an initial payment or a notice of denial of payment for an item or service. Under the IFC, the provider or facility, or plan or issuer, may engage in open negotiations to determine the total out-of-network rate (including any cost sharing).

The party initiating the open negotiation must provide written notice to the other party of its intent to negotiate. This notice must include information sufficient to identify the items or services subject to negotiation (i.e., date the item or service was furnished, the service code, the initial payment amount or notice of denial of payment, as applicable), an offer for the out-of-network rate and contact information of the party sending the open negotiation notice. Also, the open negotiation notice must be provided in writing or email under certain circumstances.[1] Notably, the Departments anticipate that most open negotiation notices will be sent electronically.

The 30-business-day open negotiation period begins on the day on which the open negotiation notice is first sent by a party. The Departments encourage parties submitting such notices to take steps to confirm the other party's contact information and receipt. In the IFC, the Departments note that it will issue a standard notice that the parties may use to satisfy the open negotiation notice requirement.

The Departments solicit comment on whether there are any challenges or additional clarifications needed to ensure the parties are afforded the full open negotiation period, including whether there are any challenges regarding designating the date the notice is sent as the commencement date of the open negotiation period.

Notice of IDR Initiation

If the parties have not reached an agreed-upon amount during open negotiations, then either party may initiate the Federal IDR process. The Federal IDR process must be initiated during a 4-business-day period beginning on the 31st business day after the start of the open negotiation period. More information regarding the timing of events during the Federal IDR process is provided in the below table.

To initiate the Federal IDR process, the initiating party must submit a notice to the other party and to the Departments (Notice of IDR Initiation) through the Federal IDR portal on the same day the notice is furnished to the non-initiating party. The Notice of IDR Initiation must include: (1) Information sufficient to identify the qualified IDR items or services (2) the names and contact information of the parties involved, including email addresses, phone numbers, and mailing addresses; (3) the state where the qualified IDR items or services were furnished; (4) the commencement date of the open negotiation period; (5) the initiating party's preferred certified IDR entity; (6) an attestation that the items or services are qualified IDR items and services within the scope of the Federal IDR process; (7) the Qualifying Payment Amount (QPA) (which is provided when the plan makes an initial payment to the provider/facility or denial of payment); (8) certain information about the QPA; and (9) general information describing the Federal IDR process.

In the IFC, the Departments note that the Federal IDR portal will be used to facilitate and support IDR entity certification, the initiation of the Federal IDR process, the selection of certified IDR entities, the submission of supporting documentation to certified IDR entities and the submission of certified IDR entity reporting metrics.

[1] According to the IFC, the party sending the open negotiation notice may satisfy the requirement to send the notice within 30 business days of the initial payment or notice of denial by providing the notice to the opposing party electronically (such as by email) if the following two conditions are satisfied: (1) The party sending the open negotiation notice has a good faith belief that the electronic method is readily accessible to the other party; and (2) the notice is provided in paper form free of charge upon request.

The Departments solicit comment on the content of the Notice of IDR Initiation and the manner for providing the notices.

Certified IDR Selection

Before the IDR process can begin, a certified IDR entity must be selected by the parties or the Departments. In some circumstances, the parties may mutually agree to a certified IDR entity if the non-initiating party fails to object to the initiating party's initial certified IDR entity selection (as specified in the notice of IDR initiation) within 3 business days of the date of initiation of the Federal IDR process and the certified IDR entity does not have any conflicts of interest. The Departments will make available on the Federal IDR portal a list of certified IDR entities among which parties to the Federal IDR process may select.

If the parties do not mutually agree upon a certified IDR entity (including in the case of no conflict-free selection), then the Departments would randomly select a certified IDR entity within 6 business day after the date of initiation of the Federal IDR process. **The Departments seek comment on whether the random selection method should be limited only to certified IDR entities that charge a fee within the allowed range or whether an alternative selection process should be used** (e.g., whether the specific fee of the certified IDR entity should be selected or other factors, like how often the certified IDR entity chooses the amount closest to the QPA).

Submission of Payment Offers and Additional Information to the Certified IDR Entity

Following selection of the certified IDR entity and confirmation from the IDR entity that the federal IDR process applies, the parties must submit payment offers. Payment offers must be submitted no later than 10 business days after the selection of the certified IDR entity. The offer must be expressed as both a dollar amount and the corresponding percentage of the QPA represented by that dollar amount.

In addition, parties must submit information requested by the certified IDR entity relating to the offer, along with information about the size of their practices and facilities. Also, parties may submit any information related to the offer (except for information related to usual and customary charges, billed amount and public payor rates which the certified IDR entity may not consider).

Payment Determination Made by the Certified IDR Entity

According to the IFC, the certified IDR entity must select one of the offers submitted by the plan or issuers or the provider or facility to be the out-of-network rate within 30 business days of the selection of the certified IDR entity. In selecting the offer, the certified IDR entity must presume that the QPA is an appropriate payment amount. In addition, it must also consider different additional circumstances (e.g., experience or level of training of a provider was necessary for providing the qualified IDR item or service to the patient or that the experience or training made an impact on the care that was provided, retrospective payment penalties, patient acuity or complexity, teaching status, case mix and scope of services, good faith efforts to enter into network agreements). In the IFC, the Departments indicate that they intend to provide additional guidance to certified IDR entities, as necessary, to clarify how the allowable factors should be considered and will seek comments.

After considering the QPA, additional information requested by the certified IDR entity from the parties and credible information that the parties submit, the certified IDR entity must select the offer closest to the QPA. However, the offer closest to the QPA would not be selected if credible

information submitted by the parties clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate.

For batched items and services, the certified IDR entity may select different offers, from either one or both parties, when the QPAs for the qualified IDR items or services within the batch are different. More information regarding batched items and services is provided below.

A certified IDR entity's payment determination is binding upon all parties involved, except in limited circumstances (e.g., fraud or intentional misrepresentation).

Payment Submitted to the Applicable Party

Any additional payments must be made no later than 30 calendar days after the determination by the certified IDR entity. This amount will be the offer selected, reduced by the sum of any initial payment the plan or issuer has paid to the provider or facility and any cost sharing paid or owed by the beneficiary to the provider or facility. The cost-sharing amount remains the same as originally calculated.

IDR Action	Timeline
Initiate 30-business-day open negotiation period	Begins on the day of initial payment or notice of denial of payment – period lasts for 30 days
Initiate IDR process following failed open negotiation	Must occur within 4 business days after the open negotiation period ends
Mutual agreement on a certified IDR entity	3 business days after the IDR initiation date
Departments select certified IDR entity in the case of no conflict-free selection by parties	6 business days after the IDR initiation date
Submit payment offers and additional information to certified IDR entity	10 business days after the date of certified IDR entity selection
Payment determination made by the certified IDR entity	30 business days after the date of certified IDR entity selection
Payment submitted to the applicable party	30 business days after the payment determination

* Note: Parties have authority to continue to negotiate outside the IDR process until the certified IDR entity has made its payment determination. The initiating party must notify the Departments and the certified IDR entity (if selected) by submitting an electronic notification no later than 3 business days after the date of the agreement. When there is an agreement after initiation and a certified IDR entity is selected but prior to a determination by the certified IDR entity, each party must pay half of the certified IDR entity fee, unless the parties agree otherwise. When an agreement is reached, either before or after a certified IDR entity is selected, notification to the Departments must include the out-of-network rate (that is, the total payment amount, including both cost sharing and the total plan or coverage payment) and signatures from an authorized signatory for each party.

Treatment of Batched Items and Services

The NSA directs the Departments to specify criteria under which multiple qualified IDR items and services may be considered jointly as part of one payment determination (i.e., batching). Under the IFC, multiple claims for qualified IDR items and services may be submitted and considered jointly as part of one payment determination by a certified IDR entity (batched items and services) only if the following conditions are met.

First, the qualified IDR items and services must be billed by the same provider or group of providers or facility or the same provider of air ambulance services (i.e., billed with the same National Provider Identifier (NPI) or Taxpayer Identification Number (TIN)). Second, the payment for the items and services would be made by the same group health plan or health insurance issuer. Third, the

qualified IDR items and services must be the same or similar items or services (as defined under the July 2021 IFC).[2] Finally, all the qualified IDR items and services must have been furnished within the same 30-business-day period, or 90-calendar-day suspension period.

The Departments note that a plan or issuer may pay a provider or facility a single payment for multiple services an individual received during a single episode of care (bundling). Per the IFC, when qualified IDR items or services that are billed by a provider or facility as part of a bundled arrangement, or where a plan or issuer makes an initial payment (or denial) as a bundled payment, then those qualified items or services may be submitted and considered as part of one payment determination by a certified IDR entity. **The Departments seek comment on the criteria for batching claims and bundling, including whether additional conditions should be added to limit batching or whether the conditions should be amended to facilitate broader batching of qualified IDR items and services. The Departments also seek comment on how frequently nonparticipating providers or nonparticipating emergency facilities will be reimbursed through a bundled payment. The Departments are also interested in feedback on whether allowing items or services included in a bundled payment by a provider or facility to be treated as one payment determination could be used to circumvent the batching requirements (e.g., by not requiring precise consideration of what specific claims within the batch should be arbitrated and which claims should not). The Departments solicit comment on whether there is a need to prescribe an alternative period for other qualified IDR items and services different from the 30-business-day period.**

Recordkeeping Requirement

The IFC requires that the certified IDR entity must maintain records of relevant documentation associated with any Federal IDR process determination for 6 years. The Departments note that this Federal recordkeeping requirement will help ensure that state and Federal oversight agencies are able to audit past determination of certified IDR entities and that parties are able to obtain records of the determinations.

Costs of the Federal IDR Process and Payment

There are two fees associated with the IDR process, an administrative fee and the certified IDR entity's fee. Each party will be able to view the certified IDR entity fees and administrative fees in the Federal IDR portal when engaging in the certified IDR entity selection process. When a certified IDR entity is selected by both of the parties or by the Departments, each party must pay to the certified IDR entity the administrative fee which is due to the Departments for participating in the Federal IDR process. In addition, when each entity provides their offer, each party must pay the entire certified IDR entity fee. The certified IDR entity will retain the certified IDR entity fee submitted by the non-prevailing party (the non-prevailing party is required to pay the certified IDR entity fee).

If the parties negotiate an out-of-network rate before the certified IDR entity makes a payment determination, then the certified IDR entity is required to return half of each party's payment for the certified IDR entity fee, unless directed otherwise by both parties to distribute the total amount of that refund in different shares.

---

[2] Under the July IFC, the same or similar item or service are as those items and services that are billed under the same service code, or a comparable code under a different procedural code system, and the Departments defined the service codes as the code that describes an item or service using Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), or Diagnosis-Related Group (DRG) codes.

Certification of IDR Entities

Under the NSA and as provided in the IFC, an IDR entity must meet certain standards and be certified by the Departments to be selected for the Federal IDR process. As noted in the IFC, the Departments will indicate through guidance the types of documentation that should be submitted for each certification standard, in what manner they should be submitted and how the documentation will be reviewed for certification. An IDR entity that satisfies the standards in the IFC and guidance issued by the Departments will be provided a certified IDR entity number and will be certified for a 5-year period, subject to the petition and revocation process.

Among other requirements, to be certified, an IDR entity must possess (directly or through contracts or other arrangements) and demonstrate sufficient arbitration and claims administration of health care services, managed care, billing, coding, medical, and legal expertise. Where the payment determination depends on patient acuity or the complexity of furnishing the qualified IDR item or service, or the level of training, experience, and quality and outcome measurements of the provider or facility that furnished the qualified IDR item or service, the IDR entity should have available medical expertise with the appropriate training and experience in the field of medicine involved in the qualified IDR item or service. Also, the IDR entity must adhere to confidentiality standards and have a process to ensure that no conflicts of interest exist between the parties and the personnel the certified IDR entity assigns to each dispute, and must screen for any material relationships between the parties and the personnel assigned to each dispute.

Regarding fees, in the IFC, the Departments indicate that the certified IDR entity may not charge a fee that is beyond the upper or lower limits for fees set forth in annual guidance published by the Departments as approved fixed fees. However, the certified IDR entity may seek approval for (and provide justification) a higher or lower fee from the Departments. The Departments would provide written approval for the certified IDR entity to charge a fee beyond the upper or lower limits for fees set forth in guidance.

Petition for Denial or Revocation of IDR Entity Certification

An individual, provider, facility, provider of air ambulance services, plan, or issuer may petition for the denial of a certification of an IDR entity or a revocation of a certification of a certified IDR entity for failure to meet the NSA's requirements. In the IFC, the Departments outline the process for submitting such a petition and the Departments' review process. Also, the Departments will make public a list of IDR entities seeking certification and certified IDR entities, to help facilitate the petition process.

Reporting of Information Relating to the Federal IDR Process for Qualified IDR Items and Services That Are Not Air Ambulance Services

Certain information related to the Federal IDR process will be available on a public website for each calendar quarter, starting in 2022. Information on the public website will be reported by the certified IDR entity and including information about qualified IDR items and services furnished on or after January 1, 2022 that were subject to payment determinations.

Extension of Time Periods for Extenuating Circumstances

In the IFC, the Departments indicate that the time periods specified in the IFC (other than the timing of the payments, including, if applicable, payments to the provider, facility or provider of air ambulance services) may be extended in the case of extenuating circumstances or at the

Departments' discretion (e.g., case-by-case basis for matters beyond the control of the parties or good cause). Parties may request an extension by submitting a Request for Extension due to Extenuating Circumstances through the Federal IDR portal, including an explanation about the extenuating circumstances and why the extension is needed. Also, for the extension to be granted, the parties must attest that prompt action will be taken to ensure that the payment determination is made as soon as administratively practicable.

External Review

The NSA requires that beginning no later than January 1, 2022, an external review process must be established related to whether payers are complying with the NSA's surprise billing and cost-sharing protections. To implement this requirement, the IFC expands existing regulations regarding external review of adverse benefit determinations by payers to account for the NSA's payer requirements. While different elements of existing health insurance regulations do not apply to grandfathered plans (e.g., certain pre-Affordable Care Act grandfathered plans are not subject to the requirement to cover certain preventive services without cost sharing), the IFC details application of the external review process to grandfathered plans and coverage when the patient protections of the NSA apply.

Protections for the Uninsured

Good Faith Estimates for Uninsured (or Self-Pay) Individuals

The NSA includes provisions that require providers and facilities to furnish good faith estimates to uninsured (or self-pay) individuals upon their request and at the time of scheduling the item or service. The IFC details the requirements for providing such a good faith estimate, including a requirement that a notification (in clear and understandable language) of the good faith estimate be provided to the patient. Also, consistent with the NSA, the IFC requires providers and facilities to specifically inquire about an individual's health coverage status.

Per the IFC, a convening provider or facility[3] is responsible for providing the good faith estimate to an uninsured (or self-pay) individual and may receive information from co-providers or co-facilities regarding a good faith estimate of the items and services it may furnish. The good faith estimate would be for the expected charges[4] for furnishing the items or services that are reasonably expected to be provided in conjunction with such scheduled or requested items or services.[5] While HHS acknowledges that unforeseen factors during the course of treatment could result in higher billed amounts than anticipated in the good faith estimate, HHS indicates it does not expect the good faith estimate to include charges for unanticipated items or services that occur due to unforeseen events. The good faith estimate must also include the expected billing and diagnostic codes for any such items or services and take into consideration expected discounts or adjustments that the provider or facility expects to apply to an uninsured (or self-pay) individual's billed charges.

---

[3] The IFC defines the term "convening health care provider of convening health care facility (convening provider or convening facility)" as the provider or facility who receives the initial request for a good faith estimate from an uninsured (or self-pay) individual and who is or, in the case of a request, would be responsible for scheduling the primary item or service

[4] "Expected charges" means, for an item or service, the cash pay rate or rate established by a provider or facility for an uninsured (or self-pay) individual, reflecting any discounts for such individuals, where the good faith estimate is being provided to an uninsured (or self-pay) individual; or the amount the provider or facility would expect to charge if the provider or facility intended to bill a plan or issuer directly for such item or service when the good faith estimate is being furnished to a plan or issuer.

[5] The good faith estimate is also to include items or services reasonably expected to be provided by another health care provider or health care facility.

Chart 1 (pg. 41-42) of the IFC provides an example of how itemized lists of expected items or services could be displayed in a good faith estimate for uninsured (or self-pay) individuals. **HHS seeks comment on publicly available resources, methods, and potential standardized formatting or design that could facilitate communication of good faith estimate information in a clear and understandable manner.**

The timing to provide the good faith estimate depends on when the care is scheduled and provided. If an individual schedules an item or service at least 3 business days before the item or service is furnished, then the good faith estimate should be provided within 1 business day after the date of scheduling. Alternatively, if the scheduling occurs at least 10 days in advance, the good faith estimate must be provided within 3-business-days after the date of scheduling. Notably, a provider or facility would furnish separate good faith estimates upon scheduling or upon request for any items or services that are necessary prior to or following provision of the primary item or service beyond the period of care (e.g., certain pre-operative or post-operative items or services like certain laboratory tests or post-discharge physical therapy). The below table provides examples of this timeline. Also, other state and federal laws may be applicable, such as laws[6] which require "covered entities" (e.g., hospitals, health clinics, health insurance issues, physician's practices) to take reasonable steps to ensure meaningful access to individuals with limited English proficiency.

Date of Scheduling	Date to Furnish the Item or Service	Latest Date to Provide Good Faith Estimate
Monday, January 3	Thursday, January 6	Tuesday, January 4
Monday, January 3	Thursday, January 14	Thursday, January 6
Not scheduled, but good faith estimate requested on Monday, January 3	Not scheduled	Thursday, January 6

The IFC clarifies the good faith estimate requirements are applicable for good faith estimates requested on or after January 1, 2022 by uninsured (or self-pay) individuals or in connection with items or services scheduled on or after January 1, 2022. Notably, in the IFC, HHS recognizes that some providers or facilities may need to establish efficient and secure communication channels for transmission of good faith estimate information between convening providers or facilities and co-providers and co-facilities. As a result, for good faith estimates provided to uninsured (or self-pay) individuals from January 1 - December 31, 2022, HHS indicates it will exercise its enforcement discretion when a good faith estimate provided to an uninsured (or self-pay) individual does not include expected charges from co-providers or co-facilities. However, if the uninsured (or self-pay) individual separately requests a good faith estimate directly from the co-provider or co-facility, HHS expects such an estimate to be provided.

HHS seeks comment on any existing challenges related to secure transmission of good faith estimate information between providers and facilities. HHS is also interested in whether publicly available standardized processes exist or could be developed that would facilitate and support efficient and timely transmission of good faith estimate information. HHS also seeks comments on how the Hospital Price Transparency requirements for hospitals (e.g., voluntary use of online price estimator tool) may be leveraged to provide a good faith estimate under these final rules.

[6] These laws include Section 1557 of the Patient Protection and Affordable Care Act, Title VI of the Civil Rights Act of 1964,[70] and Section 504 of the Rehabilitation Act of 1973.[71] Section 1557 and Title VI.

Patient-Provider Dispute Resolution

The NSA requires HHS to establish a patient-provider dispute resolution process. This process would be utilized in circumstances where an uninsured (or self-pay) individual received a good faith estimate of the expected charges but is billed an amount (including for items or services not included in the good faith estimate) that is "substantially in excess" of those expected charges. The individual may seek a determination from a selected dispute resolution (SDR) entity of the amount to be paid to the provider or facility.

In the IFC, the Departments define "substantially in excess" to mean with respect to the total billed charges by a provider or facility, an amount that is at least $400 more than the total amount of expected charges for the provider or facility listed on the good faith estimate. **HHS seeks comment on the definition for ''substantially in excess,'' including whether the $400 amount should be set higher or lower, whether there is any other specific dollar value that would be more appropriate, or whether a different method for determining ''substantially in excess'' should be considered.**

Patients will have 120 days after receiving a bill to initiate the dispute resolution process. To initiate a dispute, HHS provides that the initiation notice may be submitted through the Federal IDR portal, electronically or on paper, in a form and manner specified by HHS. An SDR entity, which HHS will contract with directly (and which will be selected once an initiation notice is sent), will be utilized during the patient-provider dispute resolution process. HHS will provide subsequent guidance regarding administrative fees and the way they must be submitted.

HHS anticipates utilizing the Federal IDR portal to facilitate the patient-provider dispute resolution process but will also provide processes to ensure accessibility of the system for communities with access issues.

Patients and providers may negotiate while the SDR entity's payment determination is pending. If the parties agree to settle on a payment amount, the provider or facility should notify the SDR entity through the Federal IDR Portal, electronically or in paper form, as soon as possible, but no later than 3 business-days after the date of the agreement. Once the SDR entity receives the notification of the settlement, the SDR entity shall close the dispute resolution case as settled and the agreed upon payment amount will apply for the items or services.

Should the parties not settle, the IFC requires that the health care provider or health care facility must submit information to the SDR entity no later than 10 business-days after the receipt of the notice from the SDR entity initiating the patient-provider dispute resolution process. The following information must be provided by the provider or facility: a copy of the good faith estimate; and a copy of the billed charges and documentation demonstrating that the difference between the billed charges and the expected charges in the good faith estimate reflects the costs of a medically necessary item or service and is based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility when the good faith estimate was provided.

The uninsured (or self-pay) individual would also provide information regarding the good faith estimate in case there are discrepancies. The provider or facility may also submit relevant information to support the billed change, such as information related to the patient's medical history; this information should be submitted within 10 business days of receiving notice from the SDR entity. An SDR would have 30 days after receipt of the information from the provider to determine the payment amount.

The IFC provides guidance regarding how an SDR entity would determine the payment amount and indicates that the median payment amount[7] is a reasonable payment amount. For medically necessary items or services based on unforeseen circumstances that could not have been reasonably anticipated by the provider or facility, then the SDR entity must determine the charge to be paid by the uninsured (or self-pay) individual as the lesser of two payment amounts – either the billed charge or the median payment amount for the same or similar service in the geographic area that is reflected in an independent database.

After making a determination for all items or services subject to the patient-provider dispute resolution, the SDR entity must add together the amounts to be paid for all items and services. If the final amount determined by the SDR entity is lower than the total billed charges, the SDR entity must reduce the final amount by the administrative fee amount paid by the individual (to account for the administrative fee charged to the provider or facility) to calculate the final payment determination amount to be paid by the uninsured (or self-pay) individual for the items or services subject to the SDR entity determination. Once the final payment determination amount has been calculated, the SDR entity must inform the uninsured (or self-pay) individual and the provider or facility. A determination by an SDR entity will be binding upon the parties involved, with limited exceptions. Also, the non-prevailing party would be assessed an administrative fee.

When a state law is in effect and provides a process for resolving disputes between an uninsured (or self-pay) individual and a provider and it meets or exceeds the NSA's consumer protections, then that state process should continue to apply. In the IFC, HHS indicates it will communicate with the state and determine whether a state law provides for such a dispute resolution process and will ensure that such process meets or exceeds certain minimum Federal requirements.

HHS seeks comment on the approach for the determination of payment amounts by the SDR entity, including the feasibility of the approach, as well as comment on alternative approaches. HHS also seeks comment on ways to reduce the incentives for providers and facilities to cover including items or services on the good faith estimate, and the circumstances, if any, in which requiring the SDR entity to set a payment amount below the expected charges in the good faith estimate would be appropriate.

What's Next?

The Departments are accepting comments on the IFC until December 6, 2021, but since it is an IFC, the regulations are effective October 7, 2021 and will generally be applicable on January 1, 2022.

Vizient's Office of Public Policy and Government Relations looks forward to hearing member feedback on this IFC. Stakeholder input plays a major role in shaping future changes to policy. We encourage you to reach out to our office if you have any questions or regarding any aspects of this IFC – both positive reactions and provisions that cause you concern. Please direct your feedback to Jenna Stern, Sr. Regulatory Affairs and Public Policy Director in Vizient's Washington, D.C. office.

[7] According to the IFC, the median payment amount is for the same or similar services in the geographic area, the is reflected in an independent data based, or if the amount reflected in the independent database is less than the expected charge in the good faith estimate, the good faith estimate amount.