DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 17-16-ESRD

DATE: **December 16, 2016**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Notice of Interim Final Rule (IFR) Third Party Payment and Information on Implementation Plan

Memorandum Summary

- **Publication:** The Centers for Medicare & Medicaid Services (CMS) has published an IFR on third party payment requirements in the Federal Register on December 14, 2016. This rule implements new requirements for Medicare-certified dialysis facilities that make financial contributions to patients in order to support enrollment in individual market health plans either directly or indirectly through a parent organization or third party.
- **The IFR establishes new standards under the End Stage Renal Disease (ESRD)** Conditions for Coverage (CfC) *42 CFR 494.70 Patient Rights (c) Standard: Right to be informed of health insurance options* and *42 CFR 494.180 Governance (k) Standard: Disclosure of financial assistance to insurers.*
- The requirements of the IFR apply to any dialysis facility offering financial contributions in the form of premium assistance to support enrollment in individual market health plans. The requirements will be effective 30 days from the date of publication with the exception of one portion of 42 CFR 494.180(k) which may be delayed to July 1, 2017 if there is a potential for a coverage gap for the beneficiary.
- A survey tool has been developed to assess compliance with the new standards pending completion of Interpretive Guidance.

Background

On December 14, 2016, the IFR concerning Third Party Payment requirements for dialysis facilities was published in the Federal Register (see https://www.gpo.gov/fdsys/pkg/FR-2016-12-14/pdf/2016-30016.pdf). This rule affects ESRD suppliers offering financial contributions to Medicare and/or Medicaid eligible patients supporting enrollment in individual market health plans. The rule implements new requirements for dialysis facilities that make financial contributions in the form of premium assistance to support enrollment in individual market health plans whether directly, indirectly, or through a third party. These requirements are intended to ensure insurance coverage decisions are made openly and transparently with full,

accurate information, and the information provided is not affected by the financial interest of the dialysis facility. The new standards apply to any dialysis facility offering financial contributions for payment of individual market plan premiums directly or by contributing to an organization that supports payment of individual market premiums. Dialysis facilities that do not offer financial assistance supporting individual market enrollment and do not make financial contributions to other entities that provide financial assistance *are not subject to the new requirements*. Dialysis facilities determined to be out of compliance with the new standards must follow standard procedures for correction of deficiencies.

Discussion

The IFR establishes two new standards under the ESRD CfC: 42 CFR 494.70 Patient Rights and 494.180 Governance:

42 CFR 494.70 (c) Standard: Right to be informed of health insurance options, requires facilities to inform ESRD patients of all health coverage options available including Medicare, Medicaid and locally available individual market plans on admission and annually. The information provided to all patients will also include the following: current and anticipated costs associated with each health plan option including covered services; care providers; prescription drug coverage; co-pays; co-insurance; deductibles; coverage limitations associated with transplant; risks for loss of coverage; penalties and enrollment periods for Medicare and the individual market. Furthermore, the dialysis facility will provide all patients with current information about financial assistance offered by the facility to support enrollment in an individual market plan including the risks associated with assistance. The facility will also be required to disclose current information regarding overall financial contributions to date that support enrollment in an individual market plan.

42 CFR 494.180 Governance (k) Standard: Disclosure of financial assistance to insurers requires applicable dialysis facilities to disclose to the health insurance issuer that premium assistance will be provided to the purchaser of the policy and must obtain the issuer's written agreement that payments will be accepted throughout the duration of the plan year to avoid interruptions in the patient's health insurance coverage.

A surveyor tool is provided to assist surveyors in assessing compliance with the new standards. This tool should be utilized pending the issuance of Interpretive Guidance. Surveyors are expected to incorporate the surveyor tool into the survey process upon the effective implementation date of the regulation.

Following the entrance conference, the surveyor should conduct an interview with the facility administrator or designated personnel using the surveyor tool and document their responses to each question. The surveyor tool consists of a total of seven questions. Question one determines whether the requirements are applicable to the facility. If the answer to question one is "no" the surveyor will not proceed to the additional questions. A "no" response to questions two through six would indicate a deficiency at *42 CFR 494.70 Patient Rights (c) Standard: Right to be informed of health insurance options* and a "no" response to question seven would indicate deficient practice at *42 CFR 494.180 Governance (k) Standard: Disclosure of financial assistance to insurers.*

Contact: Please email any questions to the ESRD mailbox at ESRDQuestions@cms.hhs.gov.

Effective Date: Immediately. This policy should be shared immediately with all survey and certification staff, their managers and the State/Regional Office training coordinators.

/s/
David R. Wright

Attachment- Evaluation of Third Party Payment Worksheet

cc: Survey and Certification Regional Office Management

Evaluation of Third Party Payment Requirements Worksheet

Facility: _____Date/Time: _____

Interviewee: _____Surveyor: _____

Interview a designated facility staff member during the entrance conference by answering the questions below. If the interviewee answers "No" to question 1 **do not** proceed further. The answer "No" for questions 2 -6 would indicate non-compliance at 494.70 Patient Rights and a "No" to question 7 would indicate non-compliance at 494.180 Governance

Questions	Response	Deficiency
Does the facility provide financial contributions to ESRD patients in the form of premium assistance to support enrollment in individual market plans directly, through a parent organization or another entity? **If No do not proceed with additional questions**	Y/N	
Does the facility provide all patients with current information about financial assistance offered by the facility, parent organization or third party to support enrollment in an individual market health plan including limitations and risks associated with assistance?	Y/N	Y/N
Does the facility provide all patients with current information regarding the facility's or parent organization's overall contributions to date made to patient's or third parties supporting enrollment in individual market health plans?	Y/N	Y/N
Does the facility provide all patients current information about available health plan options including but not limited to Medicare, Medicaid and individual market plans available to the patient on admission and annually?	Y/N	Y/N
Does the information provided to all patients include at least the following? • Current and anticipated costs associated with each health plan option including covered services,	Y/N	Y/N

Questions	Response	Deficiency
care providers, prescription drug coverage, co-pays, co-insurance, deductibles and enrollment periods for Medicare and the individual market • Coverage limitations associated with transplant including patient costs for pre and post-transplant care of patient and living donor • Risk for loss of coverage and possible penalties		
Does the Social Worker or a designated staff member review all the above information with each patient and answers questions or concerns identified by the patient regarding health insurance options in the context of the patient's individualized plan of care?	Y/N	Y/N
Does the facility have policies and procedures for • Communication with individual market health insurance issuers to disclose the facility's intent to offer financial assistance to patients supporting enrollment in an individual market plan • Obtaining the issuer's agreement to accept payments for duration of plan year	Y/N	Y/N