American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Regulation Summary

No Surprises Act Final Rule

Background

On August 19, 2022, the U.S. Departments of Health and Human Services (HHS), Treasury, and Labor (the Departments) issued a final rule finalizing certain policies related to the *No Surprises Act*. Along with the final rule, the Departments also issued supporting documents, including a set of frequently asked questions (FAQs) and an update on the federal independent dispute resolution (IDR) process.

The *No Surprises Act*, which was included in the Consolidated Appropriations Act that passed in December 2020, bans balance billing for out-of-network services starting January 1, 2022, and establishes a back-stop IDR process to ensure that clinicians and facilities are paid appropriately for the out-of-network services they deliver.

The Departments had previously released two interim final rules implementing the *No Surprises Act*: the first on July 13, 2021 (IFR # 1) and the second on October 7, 2021 (IFR # 2). ACEP and the Emergency Department Practice Management Association (EDPMA) submitted comprehensive responses to the government for both IFRs.

- ACEP Summary of IFR # 1
- ACEP and EDPMA Response to IFR # 1
- ACEP Summary of IFR # 2
- ACEP and EDPMA Response to IFR # 2

This final rule addresses a couple of the issues outlined in the previous IFRs, including a flawed implementation that gave unequal weight to the Qualified Payment Amount (QPA), tilting the process unreasonably in favor of insurance companies. ACEP filed suit against the government in conjunction with the American College of Radiology and the American Society of Anesthesiologists in early 2022 to contest this policy

Overall, this summary provides the following—note that where "provider" is referenced, it's used in the statutorily defined sense, and therefore could pertain to either the billing physician, group, or facility:

Final Rule

- Background Discussion of the IFR
- Open Negotiations Required Form and Health Plan Portals
- QPA Disclosure Requirements and Downcoding
- Payment Determinations Under the Federal IDR Process
- Written Decisions from the Certified IDR Entity

Supporting Documents

- Frequently Asked Questions
- IDR Process Status Update

Final Rule

Background Discussion of the Final Rule

- The final rule includes provisions only related to the disclosure requirements that health plans must share about the QPA at the time of the initial payment and notice of denial and requirements around the IDR process in light of two court cases that vacated (i.e. invalidated) portions of IFR # 2.

- The court cases are: the United States District Court for the Eastern District of Texas, in the cases of *Texas Medical Association, et al. v. United States Department of Health and Human Services, et al.,* Case No. 6:21-cv-425 (E.D. Tex.) (*Texas Medical Association*); and *LifeNet, Inc. v. United States Department of Health and Human Services, et al.*, Case No. 6:22-cv-162 (E.D. Tex.) (*LifeNet*).
- These court cases ***invalidated*** the policy that the IDR certified entity (i.e., the independent arbiter that resolves disputes in the federal IDR process) must consider the QPA to be the presumptive payment amount in the IDR process both for providers (the *Texas Medical Association)* and air ambulance providers *(LifeNet*).

- **The Departments note that this final rule is "purposefully narrow in scope and is intended to address only certain issues critical to the implementation and effective operation of the Federal IDR process." The Departments intend to finalize the remaining provisions of IFR # 1 and IFR # 2 after further consideration of comments.**
- All the provisions in the rule are effective 60 days after the rule is published in the Federal Register (as of the date of this summary, the rule has yet to be published in the Federal Register).

Open Negotiations Required Form and Health Plan Portals

- In IFR #1, the Departments laid out disclosure requirements that the health plan must provide at the time of the initial payment or notice of denial. These include the QPA for the service and a statement that the provider can initiate open negotiations within 30 business days, which includes the contact information (phone number and email address) for the individual at the health plan responsible for open negotiations process.
- The Departments are aware of some plans requiring providers to use plan-owned proprietary web systems to initiate an open negotiations period. The Departments clarify that when a provider wishes to initiate open negotiations, they must use a standard notice of initiation of Open Negotiation issued by the Departments.
- Providers may trigger the open negotiations period by sending the notice electronically if the provider sending the notice has a good faith belief that the electronic method is readily accessible to the health plan and the notice is also provided free of charge in paper form upon request.
- **While health plans can create open negotiations portals, they cannot refuse to accept the standard notice of initiation of open negotiation from a provider, and providers are not required to use the online portal. In other words, regardless of whether the portal is used, the 30-day clock for open negotiations begins when the provider sends the notice of open negotiations to the health plan.**

QPA Disclosure Requirements and Downcoding

- Many commenters on IFR # 1, including ACEP, stressed that the methodology to calculate the QPA should be transparent, and that the Departments should expand the range of information that is shared with providers.
- One such piece of information that we had specifically requested in our comments on IFR#1 related to downcoded claims. We, along with other commenters, stated that when claims are downcoded, providers should receive the QPA both for the downcoded code and for the billed service.
    - For example, if a provider billed an emergency department (ED) evaluation and management (E/M) Level 5 service (CPT 99285), but the health plan downcoded the claim to an ED E/M level 4 (CPT 99284), then the health plan should provide the QPAs both for a 99284 and a 99285. That way, providers would have enough information to make an appropriate offer during the federal IDR process. If providers do not have the QPAs both for the billed service and for the downcoded code, they would be at a disadvantage during negotiations.
- In this final rule, the Departments state that providing this information would increase transparency. It would also help the certified IDR entity in selecting the offer that best represents the value of the service. The certified IDR entity could determine that the QPA based on the downcoded service code does not fully encompass the complexity of delivering the service because it was based on a service code for a different service from the one furnished.
- **Therefore, the Departments are requiring that, for downcoded claims, health plans must provide at the time of the initial payment or notice of denial:**
    - **A statement that the service code or modifier billed by the provider was downcoded;**
    - **An explanation of why the claim was downcoded, including a description of which service codes were altered, if any, and which modifiers were altered, added, or removed, if any; and**
    - **The amount that would have been the QPA had the service code or modifier not been downcoded.**
- **The Departments are also adding a formal definition of downcoding.**

- **Downcoding means "the alteration by a plan or issuer of a service code to another service code, or the alteration, addition, or removal by a plan or issuer of a modifier, if the changed code or modifier is associated with a lower QPA than the service code or modifier billed by the provider."**
- The Departments are continuing to consider whether additional disclosures related to the QPA calculation methodology should be required. The Departments (and certain state authorities) are responsible for determining the accuracy of plans' QPA calculations by requiring audits, and they have committed to conducting these audits.

Payment Determinations Under the Federal IDR Process

- The Presumptive QPA Policy
  - IFR # 2 had required the certified IDR entity to first look at the QPA and then to additional information provided by the parties when rendering its decisions. After considering the QPA and additional information, IFR # 2 required the certified IDR entity to select the offer closest to the QPA, unless the certified IDR entity determined that the additional factors demonstrated that the QPA was materially different from the appropriate out-of-network rate. In other words, the QPA was the presumptive payment amount. ACEP has previously argued that this policy is extremely flawed and goes against the intent of Congress.
    - The additional factors beyond the QPA include:
      - The level of training, experience, and quality and outcomes measurements of the provider
      - The market share of the provider or the health plan
      - The acuity of the patient who received the service
      - The teaching status, case mix, and scope of services of the facility that furnished the service
      - Demonstration of good faith efforts (or lack thereof) made by the provider or the plan to enter into network agreements with each other, and, if applicable, contracted rates between the provider or facility and the plan during the previous 4 plan years.
  - **The District Court in Texas Medical Association and LifeNet invalidated this policy—and the Departments are therefore officially removing this policy from the regulation via this final rule.**
- QPA
  - The Departments note that the QPA will always be relevant to a payment determination in the IDR process, as it "represents the typical payment amount that a plan […] will pay in-network providers […] for that particular qualified IDR […] service."
  - The QPA, if calculated according to the regulatory requirements, is also considered to be "credible."
  - The Departments note that the QPA is a quantitative number, and the other factors a certified IDR entity can consider are mostly qualitative. In order to consider these other factors in a consistent way, the Departments create additional policies (described below) to "promote consistency and predictability in the process, thereby lowering administrative costs and encouraging consistency in appropriate payments for out-of-network services."
  - The Departments claim that the statute requires certified IDR entities to always consider the QPA when making a payment determination. Consideration of the QPA, which is the first-listed statutory factor in the *No Surprises Act*, will aid certified IDR entities in their consideration of each of the other factors. The certified IDR entities will have to evaluate whether the additional factors present information that may not have already been captured in the calculation of the QPA.
- Selecting the Offer
  - The Departments believe that it "will often be the case that the QPA represents an appropriate out-of-network rate, as the QPA is largely informed by similar information to what would be provided as information in support of the additional statutory circumstances." However, the Departments acknowledge that the additional factors may be relevant in determining the appropriate out-of-network rate.
  - The final rule does NOT require the certified IDR entity to select the offer closest to the QPA but specifies that certified IDR entities should select the offer that best represents the value of the service after considering the QPA and all permissible information submitted by the parties. In considering additional factors and information, the certified IDR entity should evaluate whether information that is offered is credible and should not give weight to information that is not credible.
- Avoid Double Counting Information
  - The final rule states that the certified IDR entity should also consider whether the additional factors or information are already accounted for in the QPA and should not give weight to information related to a

factor if the certified IDR entity determines the information was already accounted for in the calculation of the QPA, to avoid weighting the same information twice.
    - The rule provides as an example that because the plan is required to calculate the QPA using median contracted rates for service codes, and because service codes in many cases reflect patient acuity and the complexity of the service provided, these factors will often already be reflected in the QPA.
    - The Departments note in the rule that they are also aware that there are instances when certain factors related to the service may not be adequately reflected in the QPA.
  - The Departments believe that, in many cases, the additional factors for the certified IDR entity to consider other than the QPA will already be reflected in the QPA. Giving additional weight to information that is already incorporated into the calculation of the QPA would be redundant, they note, possibly resulting in the selection of an offer that does not best represent the value of the service and potentially over time contributing to higher health care costs.
    - Certified IDR entities are required to consider the QPA and then must consider all additional information submitted by the parties, but each factor should be weighted only once. To the extent a factor is not already reflected in the QPA, the certified IDR entity should give that factor appropriate weight based on information related to it provided by the parties.
  - The Departments provide five examples to illustrate the consideration of factors when making a payment determination.
    - One example (example # 3) relates to an ED E/M service, where a provider submits an offer higher than the QPA. Along with the offer, the provider submits additional, credible information showing the acuity of the patient's condition and the complexity of the IDR service, along with the medical decision making. The health plan submits an offer equal to the QPA for CPT 99285. The health plan also submits additional, credible information showing that this CPT code accounts for the acuity of the patient's condition. If the certified IDR entity determines the information on the acuity of the patient and complexity of the service is already accounted for in the calculation of the QPA, the certified IDR entity should not give weight to the additional information provided by the provider. If, after evaluating the information submitted by the parties, the IDR entity determines that the health plan's offer best represents the value of the service, then the certified IDR entity should select the health plan's offer.
  - The Departments reiterate that a certified IDR entity cannot evaluate certain factors, including:
    - The usual and customary charges
    - Public payor rates (i.e., Medicare rates)
      - The Departments note that contracted rates are frequently based on a percentage of rates payable by Medicare, and it is acceptable if health plans submit information about these rates to certified IDR entities. Further, in the case of a retired individual who is over age 65 and enrolled in the Federal Employees Health Benefits (FEHB) Program but not covered by Medicare, by law, health plans may not pay a charge imposed by a hospital provider for inpatient services or a physician to the extent that charge exceeds applicable Medicare limits.
  - The Departments are "committed to establishing a fair, cost-effective, and reasonable IDR payment determination process that does not have an inflationary impact on health care costs." Thus, the Departments will monitor the effects of requirements and make appropriate adjustments as necessary to achieve the intended goals.

Written Decisions from the Certified IDR Entity

- Certified IDR entities are required to report each decision to the Departments. The Departments are finalizing standards for the written decision that are intended to achieve transparency and consistency in the Federal IDR process.
  - Certified IDR entities must include their rationale for the decision, along with what information the certified IDR entity considered when making its decision, including the weight given to the QPA and any additional credible information.
  - If the certified IDR entity relies on additional information in selecting an offer, its written decision must include an explanation of why the certified IDR entity concluded that this information was not already reflected in the QPA.

Supporting Documents

Frequently Asked Questions (FAQs)

- The Departments provide answers to 23 FAQs in this accompanying document.
- FAQs 1 and 2 relate to plans that use reference-based pricing.
- FAQs 3 and 4 relate to plans that do not have a network of providers that calculate cost sharing and the out-of-network rate for out-of-network services.
- FAQ 5 relates to maximum-out-of-pocket requirements for plans that do not have a network of providers.
- FAQ 6 relates to the requirements for health plans that generally do not provide out-of-network coverage.
- FAQs 7, 8, and 9 relate to requirements for air ambulance services.
- FAQ 10 clarifies how the surprise billing requirements apply to emergency services furnished with respect to a visit to a behavioral health crisis facility.
- FAQs 11 and 12 relate to reporting requirements for health plans.
- FAQ 13 clarifies which version of the standard notice and form should be used by providers.
- **FAQ 14 discusses "ghost rates" in insurer QPA calculations, which are leading to artificially low QPAs. Under this practice, which was illuminated by a recent Avalere study that ACEP, the American College of Radiology, and the American Society of Anesthesiology commissioned jointly, health plans are including rates for certain specialty services in the contracts of other unrelated specialists who rarely or never bill for the service. Since these specialists never bill for the service, often they do not negotiate the rate in their contracts, and simply accept the low rate offered by the insurer.**
    - **The Departments are now requiring plans to calculate a separate median contracted rate for each provider specialty if the contracted rates for a service varies based on the specialty. For example, if the median contracted rates for emergency medicine services are clustered around a certain amount for emergency physician contracts, but at another, materially different rate for all other specialists, the insurer would be required to calculate separate QPAs. The Departments will give health plans 90 days from August 19, 2022 (November 17, 2022) to start calculating QPAs in this way.**
- FAQ 15 clarifies that a single self-insured group health plan that offers multiple benefit package options administered by different third-party administrators can calculate a median contracted rate separately for those benefit package options.
- FAQ 16 states that health plans must issue an initial payment or notice of denial within 30 calendar days of receiving a "clean claim" from a provider. If providers have an issue with a health plan not providing the initial payment or notice of denial within this time period, they can contact the No Surprises Help Desk at 1-800-985-3059 or submit a complaint at https://www.cms.gov/nosurprises/policies-and-resources/providers-submit-a-billing-complaint.
- FAQ 17 and 18 relates to the open negotiations period and initial payment and notice of denial for services for air ambulance services.
- FAQ 19 lists out all the information that health plans must disclose at the time of the initial payment or notice of denial:
    - The QPA.
    - If the QPA is based on a downcoded service code, a statement from the plan explaining that the service billed by the provider was downcoded; an explanation of why the claim was downcoded; and the amount that would have been the QPA had the service code or modifier not been downcoded.
    - A statement to certify that the plan has determined that the QPA applies for the purposes of the recognized amount and that each QPA was calculated in accordance with the methodology outlined in IFR # 1.
    - A statement that if the provider wishes to initiate a open negotiation period, the provider may contact the appropriate person or office to initiate open negotiation, and that if the 30-business-day open negotiation period does not result in a determination, the provider may initiate the Federal IDR process within 4 days.
    - Contact information, including a telephone number and email address, for the appropriate person or office to initiate open negotiations.
- FAQ 20 states that **if a health plan fails to provide all the required information, a provider can still initiate the open negotiations period within 30 business days of receiving the initial payment or notice of denial.** The federal IDR process can be initiated 30 business days after open negotiation period begins. In other words, the timelines for both the open negotiation and federal IDR processes remain intact.

    - Providers do have the option of requesting an extension to initiate the Federal IDR process by emailing a request for extension due to extenuating circumstances to FederalIDRQuestions@cms.hhs.gov. Providers can also submit a formal complaint.
    - Failure by either party to supply information that is required may lead to a finding by the certified IDR entity that does not take into consideration the absent information or may lead to the certified IDR entity drawing an inference about the absent information that disadvantages that party.
- FAQ 21 clarifies that **it is not permissible for health plans to require the use of an online portal for providers to initiate the open negotiations period and to refuse to accept the standard open negotiation form.** The Departments reaffirm that **the initiating party may initiate the open negotiation period by sending an open negotiation notice to the other party electronically (such as by email)** if the following conditions are satisfied:
    - The initiating party has a good faith belief that the electronic method is readily accessible by the other party; and the notice is provided in paper form free of charge upon request.
    - The Departments have developed a standard open negotiation form that an initiating party must use to initiate the open negotiation period.

  Health plans can use an online portal but are required to accept the standard open negotiation form.
- FAQs 22 and 23 relate to the "transparency" requirements for health plans to disclose negotiated rates for services.

IDR Process Status Update

- The Departments provide an update on the status of submitted IDR cases, recognizing that many are backlogged and have not been resolved.
- The *No Surprises Act* requires that the Departments publish certain information about the federal IDR process for each calendar quarter. Since the IDR process went live in April 2022, there is no data to report for the first quarter of 2022. The Departments are continuing to collect and review data on the IDR process for public reporting.
- High Volume of Disputes
    - Over 46,000 disputes were initiated through the federal IDR portal between April 15th and August 11th, which is "substantially more than the Departments initially estimated would be submitted for a full year."
    - Over 1,200 disputes have been resolved, and 21,000 (nearly half) have been challenged by the non-initiating party as not eligible for the federal IDR process.
    - Certified IDR entities have already found over 7,000 disputes ineligible for the federal IDR process, and, conversely, have found that a number of the challenged claims were in fact eligible.
- Contested Dispute Eligibility
    - The primary cause of delays in the processing of disputes is the complexity of determining whether disputes are eligible for the federal IDR process. Eligibility for the federal IDR process rests on a number of factors, such as state/federal jurisdiction, correct batching and bundling, compliance with applicable time periods, and completion of open negotiations.
    - The Departments state that the process is improved when all parties provide all the required information. For this reason, the Departments published a checklist for insurance plans including the information that they are required to disclose with the initial payment or notice of denial of payment. The Departments are continuing to publish guidance to help disputing parties and certified IDR entities resolve disputes expeditiously, including the most recent set of guidance for certified IDR entities.
- Future Guidance
    - The Departments have worked to provide guidance, trainings, webinars, and other resources to stakeholders to help them understand the federal IDR process and will continue to publish additional guidance to help certified IDR entities and disputing parties resolve disputes expeditiously.