Executive Summary

Background:

HHS, Treasury, and the Dept. of Labor (Tri-Depts.) issued Interim Final Rules (IFR) under the NSA rules in July (IFR 1) and October 2021 (IFR 2), respectively.

- The Oct. IFR 2 was first challenged by the Texas Medical Association and Adam Corley, MD, and then by multiple additional parties.
- In late February 2022, the Texas Federal Court vacated major portions of IFR 2 nationwide and found that the federal rule making process violated the APA.
- In late July 2022, the Air Ambulance Association received a similar ruling from the same court striking down portions of the IFR 2 rule applicable to air ambulances.

In addition to the cases noted above, the AMA and AHA filed suit as did ACR, ACEP and ASA and then the Medical Association of GA and GA ACEP. These additional cases have not received a final disposition.

After the Texas court decision in February 2021, the Tri Depts. then withdrew the rules issued in IFR 2 and the guidance written from that rule that had been vacated by the federal court. The Depts. announced that a new final rule would be developed, and it was issued 8/19/22 (Final Rule).

Advocacy note: *There are a host of potential procedural and substantive legal questions raised by the Final Rule as these Rules relate to the prior decision in the Texas Medical Association decision (TMA). New litigation may be appropriate to raise issues regarding the Final Rules as the TMA decision is currently on appeal to the US Court of Appeals for Fifth Circuit.*

The new Final Rule will be effective 60 days after it is officially published in the Federal Register. There is at least one aspect of the Final Rule that will be delayed beyond that effectiveness deadline (see below regarding downcoding).

Important changes and differences between the Final Rule and IFR 2:

The "presumptive QPA policy" adopted in the IFR 2—that the Independent Dispute Resolution (IDR) Entities (IDREs)—must select the best and final offer in the IDR that is closest to the QPA is no longer in effect (p. 39). In addition, under the "presumptive QPA policy", IDREs were permitted to consider evidence of other statutory and regulatory IDR factors (see below) only if there was compelling evidence that the final payment should be materially different from the QPA. The Final Rule has now eliminated the "QPA presumption" and has instructed the IDREs to consider the QPA and IDR Factors as described below, subject to certain conditions.

The QPA is the median contracted rate determined by the health plan for the same or similar services and geography as of 1/1/19 adjusted for inflation. The QPA was defined in the IFR 1 to serve two main purposes:

1. Determines the patient cost sharing, (e.g., deductible and co-insurance); and
2. Serves as one (1) factor for the IDRE to consider in making the decision whether to pick one or the other best and final offer.

IDR Factors:

The IDRE must consider the additional six (6) factors provided in the NSA statute and regulations if those factors are supported by credible evidence and relate to the best and final offer. In addition to other relevant evidence as determined by the IDRE, and consideration of the QPA, the additional factors (IDR Factors) are as follows (p. 38):

1. The level of training and experience of the clinician;
2. The quality and outcome measurements of the clinician;
3. The market share of the clinician or the health plan in the geographic region in which the services were provided;
4. The acuity of the patient and complexity of the services provided to the patient;
5. The teaching status, case mix and scope of services provided by the facility; and
6. Prior contracted rates between the clinician and health plan during the previous four (4) years and demonstrations of good faith, if any, to enter into network agreements.

Advocacy Note: *The Tri Depts. perseveration with the QPA is a concern and may not be in compliance with the TMA court order. Whether current or future litigation will present that set of issues is unknown as this time, but there is general agreement that the Final Rule presents a significant question of non-compliance with the TMA ruling. While the Depts. could have simply stated in the Final rule that "no one IDR factor should be considered greater than another," the Depts. appear to clearly want the IDREs to favor the QPA over any other factor. In the final rule, the consideration of "additional factors" in addition to the QPA should only be done when those factors are not double counted (see below), are credible and relate to the party's best and final offer.*

Double Counting:

The Final Rule introduced the concept of "double counting". The Tri Depts. determined that the IDR Factors should only be counted once. The IDR Factors should not be given weight if that factor is already accounted for in information submitted by either party (p. 40).

Example: *The IDR Factors include consideration of the acuity of the patient and complexity of services to the patient. Evaluation and management (E&M) service CPT codes incorporate among other factors the medical decision making, data elements, (e.g., testing, labs and procedures) and risk to the patient. So, one could argue, the CPT code and reimbursement for that service in the QPA may have already considered the complexity of care to the patient and that complexity should not be considered twice or "double counted".*

Contracted rates stated as a percentage of a public payor, (e.g., Medicare):

The NSA statute and regulations prohibit either party from referencing governmental payor rates in the IDRE process. In a potentially troublesome development, the Tri Depts. stated in footnote 39 (p. 47) that if the physician's prior contracted rates between the health plan and the clinicians were stated as a percentage of Medicare, then the IDRE's consideration of such prior contracted rates so stated does not violate the prohibition on considering the prohibited factors. Importantly, the Tri Depts. also state in the footnote that there can be no other reference to governmental payor rates or reimbursement in the course of the IDR.

The issue is that an unsophisticated IDRE could also improperly consider that a prior contracted rate at "125 percent of current Medicare" was generous and fail to understand that the Medicare physician fee schedule has declined in real dollar terms, over 60 percent, since its creation in 1992. While he or she may know that the prior contracted rate was above Medicare rates, the physicians could not bring in evidence showing that there has been no inflation adjustment to Medicare.

Downcoding:

The Tri Depts. responded to stakeholder complaints that health plans frequently, and without justification, simply "downcode" and "down pay" the claims and codes submitted, usually based on the final diagnosis of the patient and not the patient's presenting signs and symptoms. "Downcoding" has now been officially defined in the Final Rule, "…alternation by the plan or issuer of a service code to another service code, or the alteration, addition or removal 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".

In a significant and positive development, the Tri Depts. will require that the plans explain the downcoding, describe which codes were altered, and the QPA of the service code, had the claims not been downcoded (p. 31-32). Finally, the Depts. state that the health plans may need additional time to come into compliance with these requirements, but no specific deadline is provided for in the Final Rule.

Advocacy Note: *Stakeholders should press the Depts. to specify how the downcoding requirements and their explanations will be made to clinicians, how the requirements will be enforced and the specific period when compliance by the plans will be mandatory.*

Federal Employee Health Benefit Plan (FEHBP) Beneficiaries:

Finally, If a patient is covered by the FEHBP, is over 65 years old but not covered by Medicare Part A or B, the IDRE cannot award a clinician or facility more than the Medicare fee schedule per the Depts. interpretation on 5 USC Section 8904 (b),(p. 47, footnote 40). So there may be little utility or upside in bringing such cases into the IDR.

The following is a summary of a separate list of FAQs posted by CMS, which contain at least two important clarifications— 1) involving the health plan's use of "ghost rates" (FAQ 14), and 2) involving the health plans creating an artificial, and illegal "acceptance process" for the physician's 30-day open negotiation period notice (FAQ 21).

Frequently Asked Questions (FAQs) Posted by CCIIO/CMS on Aug. 19, 2022 – highlights:

FAQ1—The prohibition on out of network (OON)/balance billing (BB) applies to patients with healthcare coverage even if the health plan has no network physicians in the plan's network.

FAQ 3—If the QPA is not calculated per the standard methodology, then the alternative methodology must be used utilizing an eligible database.

FAQ 6—The NSA applies to health plans that do not have any OON coverage.

FAQ 10—The NSA applies to behavioral health facilities if the services to the patient are part of an emergency department service regardless of whether the services are provided in a dedicated ED or FSED licensed as such.

FAQ 14— "Ghost rates" are rates negotiated by primary or multi-specialty practices that are rarely if ever coded and billed. These "ghost rates" may artificially reduce the QPA calculations by diluting specialty groups that have negotiated higher rates, plans may use "contracted rates" to calculate the median in network rate in determining the QPA. The QPA formula does not require consideration of how often the claims are reimbursed, nor the relative specialty of the groups that are reimbursed at those rates. The Depts. have now required that QPAs are calculated by specialty if the plans rates vary by specialty. Previously the Depts. said that rates could be included in the QPA calculation if the plans "offered" different rates by specialty. Clinician stakeholders have advocated for the QPAs to be based on a weighted average of claims paid for the same or similar specialty, but the Depts. revisions around the "Ghost Rates" are an improvement.

FAQ 19—The health plan is not in compliance with the NSA rules if it adjudicates the claim, states in the 835 that the claim was adjudicated per state or federal surprise billing laws and directs the clinician to the plan's website for additional information.

FAQ 21—The health plans are not in compliance with the NSA rules if they require the clinicians to use the plan's online-portal, requires data input into the portal and does not accept delivery of the CMS 30-day Open Negotiation Period notice form before the plan engages in open negotiation. UHC had required clinicians as described above but is now deemed to be out of compliance.