Final Surprise Billing Rules Released

Incrementally Provider Friendly Language Reflects TX Court Decision

The Departments of Health and Human Services, Treasury, and Labor jointly released long awaited final rules for the bipartisan No Surprises Bill on Friday, Aug. 19 after the close. The rules can be found here.

- **Final rules solidify the Interim Final Rules of July 2021, and alter the arbitration process.** The final rule offers new details for the independent dispute resolution or federal IDR process which helps determine total payment costs for out-of-network healthcare services for which the act prohibits surprise billing when agreements between providers and payers fall through.

- **The administration pivoted from its initial rule, removing requirements for the out-of-network rate to be given more weight, including the QPA over other factors.** This marks a win for providers, who had claimed that interim final rules favor payers over providers, and that an IDR should not be determined predominantly on QPAs. October 2021 interim final rules required that certified IDR entities generally select the offer closest to the QPA. The District Court vacated this requirement in rulings in February and July 2022.

- **The final rules note that QPA plus all permissible information should be considered when determining final payments.** The agencies note that their policies are driven by court decisions. District court filings struck down portions of the interim rule IDR process which required arbiters to emphasize selecting a payment amount closest to the QPA. Due to these lawsuits, final rules dictate certified IDR entities should select the best value after considering the QPA and additional permissible information from each party.

- **Insurers are somewhat displeased (HUM, UNH, CVS, EVH, others) at the watered down rule, with consumer groups slightly mote happy**. Self-insured plans note their displeasure at the final rules, noting that "According to this Final Rule, self-insured employer plan sponsors will continue to pay inflated amounts to out-of-network providers that charge unreasonable fees. This will not only increase costs for the plan sponsor but also for employees and their families covered under self-insured health plans." (ERIC)

- **IDR entities must explain payment determinations.** Final rules finalize components of the October 2021 interim final rules that require IDR entities to explain underlying payment rationale in a written decision, aiming to make claims payment processes more transparent for providers.

- **"Downcoding" is defined for the first time, as the alteration, removal, or modification of a code identified by a provider for a service by a provider.** If the QPA is downcoded, payer must provide the following information:
  - statement that the service code billed by the provider, facility, or provider of air ambulance services was downcoded
  - explanation of why the claim was downcoded, with a description of which service codes or modifiers were altered
  - amount that would have been the QPA had the service code or modifier not been downcoded

- **Departments released Frequently Asked Questions Part 55 to provide additional guidance on implementation**. FAQs address details relating to surprise billing protections, open negotiations, and the federal IDR process. The FAQs address issues such as applicability of the regulations to

Contact Ipsita Smolinski - 202.250.3741 - Ipsita@capitol-street.com

no-network and closed network plans (e.g., reference-based pricing plans); how the QPA must be calculated when a given service may be provided by different specialties; and timeliness for initial payments by payers.

- **Record # of disputes have been raised (since April 2022).** HHS notes that more than 46,000 disputes have been initiated since the IDR process launched in April 2022, far exceeding the departments' original estimates for the entire year.

- **No Surprise Act provisions apply even when a health plan does not generally provide out-of-pocket coverage.** Protections apply to emergency services, non-emergency services furnished by a nonparticipating provider with respect to a visit to a participating facility, and air ambulance services that are covered by a health plan, group, or payer, and if the group does not offer coverage for out-of-network items and services.

- **NEXT STEPS/OUR TAKE: The provisions have already started & the tweaks slightly favor providers, to align with recent court decisions, but time will tell how IRDEs treat the final rules.** Departments continue to work to implement Jan. 1, 2022 consumer protection laws. Since the No Surprises has been in effect for a while, these final rules aim to mainly streamline implementation and offer additional guidance for entities negotiating medical payments. Providers are likely pleased that IDR will take into account QPA as well as other factors.

Contact Ipsita Smolinski - 202.250.3741 - Ipsita@capitol-street.com

- **MA Oversight hearing in June 2022.** We did not hear anything new regarding MA at the House oversight hearing this summer. We view this as headline noise for now, ahead of the election, with the pressure being placed on CMS to implement long standing recommendations from government watchdog groups to the Medicare agency.

- **TOMORROW:** Please join us for a Capitol Street Summer Policy Call on Weds June 29 at 2 pm ET. We will discuss recent rulemaking for MA, how it impacts value based care / physician enablement, and the overall outlook for RADV audits, star rankings, payment reforms and potential policies in 2023+. We will also provide out outlook on BBB, as it has great momentum.

    - WHEN: Weds, June 29 at 2:00 pm ET (40 mins)
    - WHAT: Capitol Street Summer Policy Call: Medicare Advantage Issues & Outlook
    - RSVP: Please RSVP to Rasheda White at Rasheda@capitol-street.com
    - GUEST SPEAKER: Mark Newsom
    - HOST: Ipsita Smolinski
    - TOPICS Health Plan expert Mark Newsom (former CVS, Humana and CMS) and Ipsita Smolinski will discuss the MA payment outlook, touching on Medicaid (Redeterminations) as well as Marketplace trends & value-based care considerations (MA). Newsom, founder of Health Evaluations and Capitol Street Senior Strategic Advisor, will also discuss Medicaid (redeterminations) and recessionary considerations for health plans in the current economic climate of rising interest rates, clinical labor shortage, with post COVID deficit reduction on the radar for a GOP Congress. Value Based Care (VBC) programs will also be discussed as physicians benefit from MA payments. We will also discuss other legislation that impacts MA (mental health, prior auth) as well as other trends in the marketplace.

- **Today the major recommendations included prior auth legislation passage, RADV rules / coding intensity pay recoupment, better encounter data and HRA reforms.** The recommendations discussed in the hearing today were in line with the testimony released last night.
    - Erin Bliss from **OIG** recommended that CMS updates guidance on MAO's internal criteria that goes beyond coverage rules. The amount of denied care has reached alarming highs and without guidance from CMS they do not expect denials to cease, even when it is a standard or lifesaving treatment. OIG recommended that, with respect to chart reviews and HRAs, that CMS reassess the ability to allow unlinked chart reviews and HRAs to be the sole source of diagnosis for risk adjustment payments.
    - Leslie Gordon from **GAO** recommended that action be taken to ensure completeness of encounter data. Without accurate data, the risk adjustment payment cannot be sustained. Encounter data is also necessary to evaluate quality of care, as declining quality may be a reason for the alarming number of seniors changing plans in the final years of their lives. GAO emphasized also the timeliness of RADV audits and for CMS to complete them ASAP.
    - James Matthews from **MedPAC** recommended that the most important fix to MAOs is to address the excess payments that result from coding intensity. MedPAC that these practices contributed to excess payments. MedPAC urges that the Medicare program change its approach to calculating MA benchmarks. Currently they are calculated on FFS benchmarks which leads to more spending on MA.

- **All three testifying officials do not believe that terminating Medicare Advantage plans altogether is warranted**. Ranking Member Griffiths (R-GA) posed the question to which the answer was an unequivocal No. This question followed Chair DeGette's question on if the agencies believe Congress should take additional steps for course correction of MAOs which received a unanimous yes.

- **Coding intensity accounted for $12 B in additional payments, according to MedPAC study.** Again this is not new data. Diagnosis codes collected from HRAs may not have been valid or the illness could have passed, but MAOs might still be collecting additional payments from risk adjustments here. MedPAC did not assert that these diagnoses are necessarily improper or false. However, MedPAC's Dr. Matthew stated that HRA collected data ought not to be used for risk adjustment if they are not obtaining services for them. See Washington Post article here highlighting the MA practice

- **CMS was under scrutiny for not being proactive about the recommendations these agencies have proposed to increase transparency of MA plans**. Press articles note that Chiquita Brooks-LaSure was called to testify. OIG specifically stated that CMS needed to implement the changes to coding intensity, eliminate the use of in-home HRAs as the only verification of a diagnosis code, and the need to recover overpayments. The need for complete encounter data on behalf of CMS was also a repeated point of the representatives and agents during the hearing.

- **GAO prioritized the importance of meeting and speeding RADV timelines.** GAO urged the committee to follow up on the timeliness of RADV audits as they are taking much longer than expected. In 2016 GAO made two recommendations to CMS to speed up RADV as they were seeing year long delayed. CMS has completed some of the recommendations but the committee should place a priority to speed up RADV reforms.

- **A bipartisan Prior Auth Reform bill has not been CBO scored and is supported by BMA (Better Medicare Alliance) but individual plans may oppose.** There was a recommendation to pass *Improving Seniors Timely Access to Care Act* came up in a few of the Representatives' questions. This act would help in creating an electronic data processing system so that prior authorization, among other things, would be done efficiently and accurately. It will also require HHS to create a list of services that are routinely approved, encourage plans to use evidence-based guidelines in prior authorization process, and eliminate costs by decreasing administrative burden which stems from manual processing of data. This act received bipartisan support from representatives, as well as support from agencies.

- **NEXT STEPS:** There is concern that MA cuts may appear in BBB; we think that BBB is more of a drug pricing play (not MA), with perhaps small reductions possible (but unlikely). We expect July movement on BBB. Re MA, CMS's plan on implementing OIG recommendations is due in October. We expect to see movement on *Improving Seniors Timely Access to Care Act* as the bipartisan support for prior auth reform was rampant, along with the need for an online database. CMS was not in attendance today, despite reportedly being asked to testify, but the committee stated it will be discuss next steps as EnC believes MA has the potential to be great but needs work to get there.