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Updates on Final Rule Release for the No Surprises Act

APS' last update on the No Surprises Act was published in June of 2022. That update outlined the major legal efforts being made by providers and advocates to resist unreasonable aspects of the No Surprises Act, particularly in relation to providing good faith estimates. In August, a third final rule has been issued by the Department of Health and Human Services (HHS), this time focusing on the arbitration process and independent dispute resolution (IDR).

The major contributions of this final rule are:

- De-emphasizing the role of qualifying payment amounts (QPA) — or the median contracted rate for a service in a particular market — in determining final payment
- Eliminating the "double-counting" of relevant information when QPA calculations already accounts for it
- Requiring written explanations for the down-coding of claims

These modifications to the No Surprises Act are expected to have a moderately positive impact on providers, but that remains to be seen in practice. The prevalence of work being done in independent labs and in-office labs artificially lowers the median rate of services, and, despite the efforts of the final rule, evidence suggests that these median values are still highly influential in an arbitrator's determination of final payment rates.

Under the new final rule, arbitrators have significantly more flexibility in determining the fair market value of a given service. The final rule allows for the additional consideration of the following when calculating what they believe to be fair compensation:

- The provider's level of training and experience, along with quality and outcomes data
- The respective market shares of the provider and health plan
- The acuity of the case
- The provider's teaching status, case mix, and scope of services
- Demonstration of good-faith efforts (or lack thereof) by either party to enter into a network agreement, along with contracted rates during the four preceding years if applicable

Information that remains outside the purview of consideration includes:

- A provider's usual and customary charges
- Amounts that would have been billed if balance billing were permissible
- Medicare and Medicaid payment rates

Ultimately, the final rule is going the right direction in terms of achieving a more fair IDR process, but it has yet to fully account for the undue and negative influence of median rates and the flawed way in which those median rates are calculated.

The overwhelming number of disputes suggests that the system still has many kinks to work out, as over 46,000 disputes were initiated in the months following the opening of the IDR portal, but final resolution was only achieved for 1,200 of those cases. A number of IDR entities are even listed as not accepting new cases.

Much of this backlog stems from confusion over what constitutes a legitimate need for arbitration. According to CMS, common mistakes when initiating a dispute include:

- Incorrectly batching cases
- Incorrectly submitting disputes involving bundled IDR items or services
- Failing to use the contact information provided with the initial payment or notice of denial
- Failing to include the QPA provided with the initial payment or notice of denial
- Failing to provide documentation that open negotiations were initiated (for scenarios in which the non-initiating party reports that open negotiations did not occur)

As always, APS continues to monitor the development of this legislation and its impact on our clients' business. For more information about how the No Surprises Act could affect your business, please contact your Practice Manager.