Evaluating the HHS report on the No Surprises Act

The First Annual Report on the First Annual Report

Turquoise Health

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Executive Summary

Turquoise Health is tracking all components of The No Surprises Act (NSA), including the First Annual Report. This document focuses on a review of the report, analyzing stalled or broken processes within The NSA, and recommended pathways forward.

A summary of our findings include:

- The Qualifying Payment Amount (QPA) calculation is convoluted, opaque, and inconsistent.
  - Recommended Solution: CMS approves price transparency databases that serve as QPA calculators to allow both providers and payers the same insight into fair market rates.

- The Independent Dispute Resolution (IDR) was intended to be a last-resort process, but distrust and confusion over the QPA calculation has led many providers to feel their only option for fair payment is to call upon an IDR entity.
  - Recommended solution: Increased education on which claims qualify for the IDR process alongside clearer QPA payment calculators to minimize the need for an IDR entity.

- At the time of publication, due to data interoperability issues and administrative burdens, neither GFEs nor AEOBs are fully operational.
  - Recommended solution: Continued focus from CMS to ensure efficient creation of GFEs and AEOBs that are accurate and meaningful from day one.

Overview

On June 30th, Health and Human Services (HHS) and the Office of the Assistant Secretary for Planning and Evaluation released the first in a series of five reports required by the Consolidated Appropriations Act (CAA). The Annual Report shares progress and statistics on The No Surprises Act (NSA), enacted as a part of the CAA on 12/27/2020.

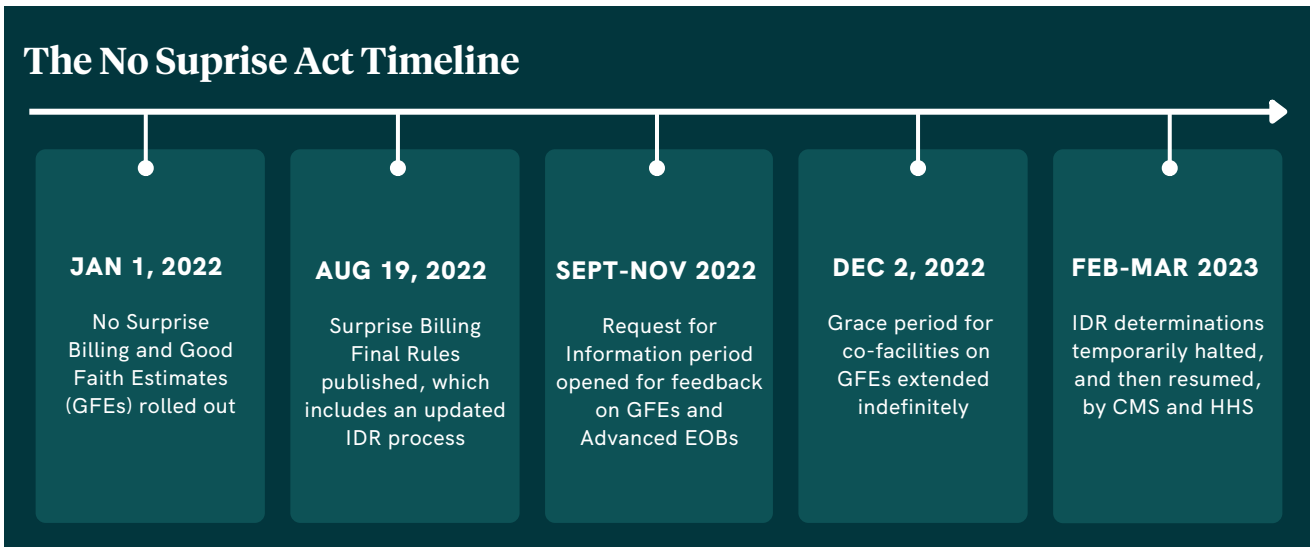
The report included statistics and a general landscape in three areas:

- State-specific actions to protect patients from receiving high bills for services provided out of network (OON) or in emergency situations, known as Surprise Billing
- Trends within healthcare consolidation and competition
- Baseline analysis of OON trends

Independent of the Annual Report, Turquoise Health has closely followed a specific subset of requirements codified in the NSA that focus on protecting patients from large, unexpected medical bills. Those protections are codified in two ways:

- Eliminating Surprise Billing, as mentioned in the Annual Report
- Instructing providers to calculate and deliver prompt pre-service estimates for both self-pay and insured patients

We are well over two years into the requirements, and the NSA is significantly wider-ranging than the three areas of focus within the Annual Report. Our goal in assessing the Annual Report is to look for a clear path toward implementing all NSA requirements, including delayed or stalled components, which are laid out below in a timeline.



Surprise Billing Ramifications for Providers and Payers

In addition to the patient-facing requirements, the NSA provided a reimbursement framework for providers and insurers when items or services are utilized during an OON or emergent episode of care.
The process, detailed through a Qualified Payment Amount (QPA), open negotiation period, and subsequent Independent Dispute Resolution (IDR), has been fraught with backlogs and lawsuits since the process began.

The IDR was intended to be a last-resort process, but distrust and confusion over the QPA calculation has led many providers to feel their only option for fair payment is to call upon an IDR entity.
According to HHS and CMS, health plans or issuers calculate the QPA based on the median contracted rate for a qualifying item or service. The median contracted rate factors in contracted rates of all plans offered by the issuer in the same insurance market for the same or similar items or services provided in the same or similar specialty or facility of the same or similar facility type in the geographic region where the item or service is furnished.

In summary, the QPA was designed to essentially serve as a proxy for the appropriate in-network rate.

IDR Reported Statistics

In April, CMS released statistics based on IDR processing between April 2022 and March 2023, and it's clear that providers do not feel the QPA payments they've received thus far match their expected in-network reimbursement. The report findings included 334,828 disputes entered the IDR queue: more than 14 times the number CMS anticipated.

Eligibility challenges and determinations proved to be a massive drain on time and resources:
- 122,781 disputes were challenged on the grounds of eligibility
- 39,890 were found to be ineligible

Within the 42,158 eligible disputes that have received payment determinations:
- 71% ruled in favor of the initiating party (likely the provider)
- 29% ruled in favor of the non-initiating party (likely the payer)

While the patient-facing solution of eliminating Surprise Billing may be working, the tenuous process of ensuring fair payments for providers must be simplified and streamlined. One possible solution: CMS publishes a list of federally-approved price transparency databases that serve QPA calculators. If both providers and insurers have the same access to how fair market rates are calculated, and those rates are calculated in line with the QPA definition laid out above, we anticipate a decreased need for IDR review. Public pricing databases may eliminate QPA opacity and decrease the gap between what providers and insurers believe to be a fair market payment.

Good Faith Estimates (GFEs) and Advanced Explanations of Benefits (AEOBs)

For patients looking to schedule planned medical or surgical procedures, The NSA requires providers to offer two different types of estimates: GFEs, for patients looking to pay a cash price, and AEOBs, for patients who will utilize their insurance.

At the time of publication, neither GFEs nor AEOBs are fully operational.

Convening and Co-Provider Estimates

For GFEs, The NSA defines two different providers: convening (the provider through whom the patient scheduled an appointment) and co-providers (any additional provider furnishing services), and both providers' estimates are required to be consolidated and shared with the patient on one comprehensive GFE within one to three business days, depending on how far in advance the appointment is created.

Convening provider GFEs have been required since 1/1/22, but there is no announced date for the inclusion of co-provider estimates. The exclusion of co-provider estimates greatly limits the number of accurate GFEs available to patients since a significant number of procedures occur with multiple clinicians delivering care. For example, a patient in need of rehabilitation due to an injury may need weekly physical therapy appointments. Those weekly appointments typically involve one clinician: a Physical Therapist. That patient could ask for a GFE and expect it to be accurate, because the patient is receiving one defined service from one convening provider. However, if that same patient needed to have surgery to heal the injury, the surgery would require a number of clinicians: a surgeon, anesthesiologist, nurses, and perhaps others. The patient now requires both a convening provider and multiple co-providers to weigh in on the cost of care. Without requiring the providers to collaborate and create one comprehensive estimate of all items and services likely to occur during the entirety of the surgical episode of care, the patient may receive numerous bills from numerous providers.

AEOBs

Similarly, enforcement of AEOBs is also delayed indefinitely due to data interoperability issues and a lack of a clear path toward automated and accurate estimates. HHS has committed to assisting providers with solutions to overcome siloed EHRs, practice management systems, and patient eligibility checks. In July, CMS hosted an HL7 Connectathon event focused on AEOB rulemaking and implementation. A key takeaway from the event was CMS' commitment to sufficient real-world testing with actual clinicians and administrative staff we'd be responsible for initiating, preparing, and delivering estimates to patients.

Progress may be slower than the industry would prefer, but CMS is looking through policy and implementation issues deliberately and carefully to make sure that these processes are to be efficient and that GFEs and AEOBs are accurate and meaningful for consumers from day one.

The solution requires innovators, payers, and providers to commit to a new world that includes APIs for quicker data exchange and proactively educating patients on how and when to request estimates.

Conclusion

In the future, we hope to see a more comprehensive Annual Report detailing noteworthy progress. This will allow HHS to confirm its commitment to all components of NSA – including those that have been temporarily delayed or those that remain under scrutiny.

We hope to see HHS assign enforcement dates to end estimate delays. There should also be clear communication on the status of the QPA calculations and IDR backlog. These crucial components must remain in the conversation to assist in eliminating the financial complexity of healthcare.