Final Report: Federal Qualifying Payment Amount Audit of
Aetna Health Inc. (a Texas corp.) – HIOS ID #58840
State of Texas as of May 29, 2024

Audit Report: 58840– 2022 – FED – QPA-1

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I. Scope of Audit

The Center for Consumer Information and Insurance Oversight (CCIIO) conducted a Qualifying Payment Amount (QPA) Audit (Audit) of Aetna Health Inc. (Issuer) pursuant to section 2723 of the Public Health Service Act (PHS Act) (implementing regulations 45 C.F.R 150.313) and section 2799A-1(a)(2) of the PHS Act (implementing regulations 45 C.F.R 149.140(f)).

The Audit Period for air ambulance service QPA calculations made and claims for air ambulance services furnished by a nonparticipating provider of air ambulance services was from January 1, 2022 through June 10, 2022. The purpose of the Audit was to assess the Issuer's compliance with Federal requirements under sections 2799A-1(a)(3)(E) and 2799A-2(a) of the PHS Act and implementing regulations:

- 45 C.F.R. § 149.130 – Preventing Surprise Medical Bills for Air Ambulance Services; and

- 45 C.F.R. § 149.140 – Methodology for Calculating Qualifying Payment Amount.

During this Audit, CCIIO requested air ambulance service claim records, data, and documents pertaining to the calculation of QPAs. CCIIO also requested Issuer-generated documents, including:

- a comprehensive list of all insurance markets in which the Issuer offers coverage;
- a narrative describing the Issuer's QPA calculation methodology;
- all claims handling manuals, internal bulletins and guidelines issued by the Issuer with respect to the processing and payment of claims;
- claims data relating to air ambulance services for which there was a requirement to apply a QPA;
- QPA calculation data;
- air ambulance provider contracts; and
- claim samples and related claim processing documents.

This report is by exception; therefore, the only areas indicated in the report are areas where findings were noted. Any additional practices, procedures, and files subject to review during the Audit are omitted from this report if no findings are indicated. Some non-compliant practices may not have been discovered or noted in this report. Failure to identify or address business practices that do not comply with Federal statutes and regulations or those of other applicable jurisdictions does not constitute CCIIO's acceptance of such practices. Please note: this report describes Issuer's compliance during the Audit Period (January 1, 2022, through June 10, 2022) with applicable regulations and guidance as modified by the court's ruling in *Texas Medical Association*

et al. v. U.S. Department of Health and Human Services et al. Case No. 6:22-cv-450-JDK (TMA III).

The audit and testing methodologies followed standards established by the National Association of Insurance Commissioners (NAIC)[1] and procedures developed by CCIIO.

The Audit's scope was limited to air ambulance service QPA calculations and air ambulance service claims subject to the No Surprises Act, and the audit was conducted pursuant to CMS's authority as outlined in CMS's letter to Texas regarding enforcement of the provisions of the Consolidated Appropriations Act, 2021.[2] Accordingly, CCIIO requested and received from the Issuer, air ambulance QPA calculation data and claims data, which is summarized in the tables below.

Air ambulance QPA calculation data (reviewed to determine the accuracy of the Issuer's QPAs):

HCPCS Code[3]	Description	Record Count[4]
A0430	Fixed Wing, One Way	40
A0431	Rotary Wing, One Way	82
A0435	Fixed Wing, Per Mile	37
A0436	Rotary Wing, Per Mile	86

All air ambulance claims data (reviewed to determine whether the Issuer provided required disclosures and made timely initial payments or notices of denial of payment):

Claim Type	Population	Sample Size	QPAs
Air Ambulance	1	1	2

We acknowledge that, since the completion of CCIIO's audit of Aetna Health Inc., the United States District Court for the Eastern District of Texas issued a ruling in TMA III.

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[1] Market Regulation Handbook Examination Standards Summary 2022. https://content.naic.org/sites/default/files/publication-mes-hb-market-handbook-examination.pdf

[2] Center for Consumer Information & Insurance Oversight, CAA Enforcement Letter to Texas (as of Jan. 25, 2022), available at https://www.cms.gov/files/document/caa-enforcement-letters-texas.pdf.

[3] Healthcare Common Procedural Coding System (HCPS) Codes (Code List) identifies all the items and services included within certain Designated Health Services (DHS).

[4] *Record Count* reflects the Issuer's initial submission of processed claims rather than contracted rates as required.

The ruling vacated certain provisions of the regulations and guidance regarding calculation of the QPA. This report describes Issuer's compliance with applicable regulations and guidance as modified by the court's ruling in TMA III.

II. Issuer Profile

Aetna Health Inc., of Texas, (Aetna) is an insurance company licensed by the Texas Department of Insurance to sell health insurance in Texas and is subject to regulation by the State of Texas as well as CCIIO. Aetna offers a range of insurance and employee benefit products, as well as related programs and services.

III. Executive Summary

CCIIO conducted an Audit to assess the Issuer's compliance with the following requirements under Title XXVII of the PHS Act:

- Section 2799A-1(a)(3)(E) of the PHS Act- Qualifying Payment Amount;
- Section 2799A-2(a) of the PHS Act – Ending Surprise Air Ambulance Bills;
- 45 C.F.R. § 149.130 – Preventing Surprise Medical Bills for Air Ambulance Services; and
- 45 C.F.R. § 149.140 – Methodology for Calculating Qualifying Payment Amount.

The period covered by the Audit for air ambulance service QPA calculations made and claims for air ambulance services furnished by a nonparticipating provider of air ambulance services was from January 1, 2022 through June 10, 2022 (Audit Period).

The Audit included the review and analysis of air ambulance service claim records, data, and documents pertaining to the calculation of QPAs. CCIIO also requested Issuer-generated documents, including: a comprehensive list of all insurance markets in which the Issuer offers coverage; a narrative describing the Issuer's QPA calculation methodology; all claims handling manuals, internal bulletins and guidelines issued by the Issuer with respect to the processing and payment of claims; claims data relating to air ambulance services for which there was a requirement to apply a QPA; QPA calculation data; air ambulance provider contracts; and claim samples and related claim processing documents.

This report is by exception; therefore, the only areas indicated in the report are areas where findings were noted. Any additional practices, procedures, and files subject to review during the Audit are omitted from this report if no findings are indicated. Please note that this report describes Issuer's compliance during the Audit Period with applicable regulations and guidance as modified by the court's ruling in TMA III.

In summary, findings were identified regarding the following Federal requirements:

Finding 1	
Summary	Failing to properly calculate the QPA by using claim paid amounts instead of contracted rates, and counting each claim as its own contracted rate, even when the claims were for the same amounts for the same item or service and to the same provider of air ambulance services. *(See Table 2 below which*

Finding 1	
	delineates whether the reported QPA was higher or lower than the correctly calculated QPA.)
Citation	45 C.F.R. §§ 149.140(b)(1) and (c)(1)(i)
Corrective Action	**<u>Completed Corrective Actions:</u>** The Issuer correctly recalculated the five QPAs using contracted rates rather than paid claims identified during the Audit. No further action is required with respect to these five QPAs. **<u>Further Required Corrective Actions:</u>** Conduct a self-audit of all QPA calculations made and claims for air ambulance services furnished by a nonparticipating provider of air ambulance services, from January 1, 2022 through the date of this final report, to identify claims for which the reported QPA was higher than it should have been if calculated correctly. For those claims, refund to the consumer the cost-sharing differential amount that should have been owed based on the lower correct QPA. For claims for which the reported QPA was lower than it should have been if calculated correctly, no action is recommended. Plans and issuers are expected to calculate QPAs using a good faith, reasonable interpretation of the applicable statutes and regulations that remain in effect after the *TMA III* decision.[5] Additionally, CCIIO will exercise enforcement discretion under the relevant No Surprises Act provisions for any plan or issuer that uses a QPA calculated in accordance with the methodology under the July 2021 interim final rules and guidance in effect immediately before the decision in *TMA III* for items and services furnished before November 1, 2024.[6] This exercise of enforcement discretion applies to QPAs for purposes of patient cost sharing, providing required disclosures with an initial payment or notice of denial of payment, and providing required disclosures and

[5] FAQs About Consolidated Appropriation Act, 2021 Implementation Part 67 (May 1, 2024), available at https://www.cms.gov/files/document/faqs-part-67.pdf.
[6] *Id*.

Finding 1	
	submissions under the Federal Independent Dispute Resolution (IDR) process.[7] Within 45 calendar days of receipt of this final report, provide documents containing the results from the self-audit and any documented cost-sharing differential amount to CCIIO. The results should contain the claim numbers, dates of service, dates of initial payment or notice of denial of payment, corrected QPAs, and amounts and dates of refund payments to consumers.
Finding 2	
Summary	Failing to provide a statement that generally the provider may initiate the IDR process within four days after the end of open negotiation period.
Citation	45 C.F.R. § 149.140(d)(1)(iv)
Corrective Action	**Completed Corrective Actions:** None. **Further Required Corrective Actions:** Implement a system upgrade to update the non-compliant disclosure language to meet the requirements. Conduct a self-audit of all claims for air ambulance services furnished by a nonparticipating provider of air ambulance services, from January 1, 2022 through the date of this final report, to identify any claims for which the Issuer failed to provide a compliant statement that, generally, the provider or facility may initiate the IDR process within four days after the end of the open negotiation period. Within 45 calendar days of receipt of this final report, provide documentation of the system update and the results from the self-audit to CCIIO. The results should contain the claim numbers, dates of service, and dates of initial payment or notice of denial of payment.

[7] *Id.*

Finding 3	
Summary	Failing to share the QPA in a remittance advice sent with an initial payment or in a notice of denial of payment.
Citation	45 C.F.R. § 149.140(d)(1)(i)
Corrective Action	**Completed Corrective Actions:** The Issuer implemented a system upgrade which included adding a QPA field to all disclosures provided with initial payments and notices of denial of payment for items and services for which the QPA applies, reprocessed the one claim identified during the Audit that failed to include the QPA, and shared the QPA with the nonparticipating provider of air ambulance services. No further action is required with respect to the identified claim. **Further Required Corrective Actions:** Conduct a self-audit of all claims for air ambulance services furnished by a nonparticipating provider of air ambulance services, from January 1, 2022 through the date of this final report, to identify any claims for which the cost-sharing amount was required to be calculated based on the QPA and for which the Issuer failed to share the QPA in a remittance advice sent with an initial payment or notice of denial of payment. Within 45 calendar days of receipt of this final report, provide documentation containing the results from the self-audit to CCIIO. The results should contain the claim numbers, dates of service, and dates of initial payment or notice of denial of payment.

One observation was identified regarding the Federal QPA Calculation Methodology Requirements:

Observation	
Summary	Failing to calculate the QPA in accordance with then-applicable rules by excluding contracted rates for contracts under which no claims were filed.
Citation	45 C.F.R. §§ 149.140(b)(1) and (c)(1)
Notes	The requirement to include contracted rates regardless of the number of claims paid at that contracted rate was vacated by the court decision in TMA III.

Additional details regarding these findings and observation are in the Audit Results section of this report.

The Audit identified practices that did not comply with Federal requirements applicable at the time subject to the Audit. CCIIO strongly recommends that the Issuer share with and apply the corrective actions outlined in this Audit Report to all of its affiliates, regardless of situs or regulatory jurisdiction for No Surprises Act-eligible claims. Additionally, the Issuer may be subject to future audits.

IV. Audit Results

A. QPA Calculation Methodology Requirements Findings

Violation of 45 C.F.R. §§ 149.140(b)(1) and (c)(1)(i).

CCIIO identified a finding of these provisions in the following instances:

Finding 1 – Failing to properly calculate the QPA by using claim paid amounts instead of contracted rates, and counting each claim as its own contracted rate, even when the claims were for the same amounts for the same item or service and to the same provider of air ambulance services.

CCIIO reviewed the Issuer's policies and procedures for calculating QPAs, as well as the Issuer's complete list of QPAs for air ambulance service calculations made and claims for air ambulance services furnished by a nonparticipating provider of air ambulance services during the Audit Period. CCIIO determined that the Issuer did not properly calculate QPAs as required by 45 C.F.R. §§ 149.140(b)(1) and (c)(1)(i). Specifically, the Issuer incorrectly used claim paid amounts, from both participating and non-participating providers of air ambulance services, rather than using contracted rates with participating providers of air ambulance services recognized on January 31, 2019. In addition, the Issuer counted each claim paid amount as its own contracted rate, even when the claim paid amounts were the same and from the same provider of air ambulance services. The Issuer's incorrect QPA calculation methodology impacted five QPAs under four HCPCS codes.

HCPCS Code	Description
A0430	Fixed Wing, One Way
A0431[8]	Rotary Wing, One Way
A0435	Fixed Wing, Per Mile
A0436	Rotary Wing, Per Mile

[8] CMS notes that for A0431, there were two QPAs calculated incorrectly, one for each of two different geographic regions.

In general, the QPA is defined as the median of the contracted rates recognized by the plan or issuer on January 31, 2019, for the same or similar item or service that is provided by a provider in the same or similar specialty or facility of the same or similar facility type[9] and provided in a geographic region in which the item or service is furnished, increased for inflation.

In determining the median contracted rate, each of the contracted rates negotiated under a separate contract is treated as a separate contracted rate.[10] If a plan or issuer has a contract with a provider group or facility, the rate negotiated with that provider group or facility under the contract is treated as a single contracted rate if the same amount applies with respect to all providers of such provider group or facility under the single contract. However, if a plan or issuer contracts with multiple providers, with separate negotiated rates with each particular provider, each unique contracted rate with an individual provider constitutes a single contracted rate. Further, if a plan or issuer has separate contracts with individual providers, the contracted rate under each such contract constitutes a single contracted rate (even if the same amount is paid to multiple providers under separate contracts). For example, if a plan or issuer has a contract with a provider group that has three providers performing services under a single contract at the same negotiated rate, the issuer is required to count that rate as one contracted rate. However, if the provider group has three providers performing services under its contract at three different negotiated rates, the issuer is required to count each rate as three separate contracted rates for purposes of determining the median contracted rate used to calculate the QPA.

CCIIO requested that the Issuer provide a step-by-step narrative and supporting documentation for its QPA calculation methodology. In response, the Issuer provided two documents: *CL-2_NSA QPA Step-by-Step Methodology* (Methodology); and *CL-2_NSA QPA Rate Development* (Rate Development). The Methodology document mirrored the QPA calculation methodology requirements outlined in regulations, including a reference to "contracted rates recognized by the plan or issuer on January 31, 2019" (Methodology, p. 1).

The Rate Development document, however, contained information that conflicted with the Methodology document, and contained information that was inconsistent with the methodology requirements outlined in statute and regulations. The air ambulance section of the Rate Development document stated, "Using Par provider claims that have

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[9] For these purposes, all air ambulance service providers are considered to be a single provider specialty. 45 C.F.R. § 149.140(a)(12).
[10] 45 C.F.R. § 149.140(b)(1).

dates of service 1/1/2019-12/31/2019", and "We base our QPA on a minimum of three contracted rates which are calculated by MSA or by state." (Rate Development, p. 3).

Because of the conflicting information and information inconsistent with the methodology requirements outlined in statute and regulations, CCIIO sought clarification. CCIIO issued a Request for Information (RFI) asking whether the Issuer had contracted rates for air ambulance services, requesting confirmation that the Issuer used the median of contracted rates recognized on January 31, 2019, for all coverage offered by the Issuer in the same insurance market, and asking for clarification regarding why the Issuer referenced claims instead of contracted rates as well as dates of service, "1/1/2019 – 12/31/2019", in the Rate Development document.

The Issuer produced *RFI Response_Final 08.26.2022*, and again provided conflicting information, stating that it used both compliant and non-compliant practices and which did not appear to overlap:

- "Yes, we have contracted rates for Air Ambulance providers."
- "We are using the participating provider contracted rates effective the entire calendar year of 2019."
- "For air ambulance, because we needed to use a claim-based approach, we used the entire 2019 calendar year. Since our contracts renew on January 1st each year, the rates effective on 1/31 and the following December are the same."

CCIIO also requested the Issuer's QPA calculation data, the Issuer produced *CL-4-b_QPA Calc File Narrative_09.02.2022* (QPA Data 09/02/22). The document did not contain contracted rates. Rather, the document contained records for 245 claim paid amounts and made several references to using "claims" to calculate the QPA.

Again, CCIIO sought clarification of whether the Issuer used contracted rates or claim paid amounts to calculate the QPA. CCIIO issued an RFI requesting a list of the Issuer's complete universe of participating air ambulance service providers within the Audit Period, as well as the underlying contracts.

In response, the Issuer provided a complete list of its participating air ambulance providers and each corresponding contract. CCIIO compared the Issuer's air ambulance provider contracts to QPA Data 09/02/22 and identified discrepancies that impacted the accuracy of the QPAs. Specifically, the Issuer used all claim paid amounts and did not separate amounts by each provider or provider group as required if the Issuer would have correctly provided the contacted rates rather than the claim paid amounts. QPA Data 09/02/22 also showed that the Issuer included in the calculation of three QPAs the

amount the Issuer paid to two air ambulance providers with whom they produced no evidence of a direct or indirect contract that would establish a contracted rate. Listed below is a summary of the identified discrepancies:

Table #1: Comparison of Data to Contracts

HCPCS Code	Description	Claim Data: Incorrect Record Count	Contracts: Correct Record Count
A0430	Fixed Wing, One Way	40	6
A0431	Rotary Wing, One Way	82	4
A0435	Fixed Wing, Per Mile	37	6
A0436	Rotary Wing, Per Mile	86	4

The Issuer also produced *QPA_CalcDataFileFormat_09.22.2022* (QPA Data 09/22/22), which was the Issuer's QPA calculation data using contracted rates. CCIIO compared the Issuer's air ambulance provider contracts to QPA Data 09/22/22. CCIIO confirmed the accuracy of the contract count and calculated QPAs in QPA Data 09/22/22.

CCIIO then compared QPA Data 09/02/22, which was the Issuer's original QPA calculation data, incorrectly using claims experience, and QPA Data 09/22/22, which was the Issuer's updated QPA calculation data, correctly using contracted rates (based on the methodology prior to the court decision in *TMA III*). Five incorrect QPAs were identified in QPA Data 09/02/22 and are included in this Finding 1. Listed below is a summary of the comparison between the incorrect QPAs in QPA Data 09/02/22 and the correctly recalculated QPAs in QPA Data 09/22/22:

Table #2: QPA Comparison Between Data Sets				
HCPCS Code	**Description**	**Geographic Region[11]**	**Incorrect to Correct QPA, % Difference[12,13]**	**Impacted Claim Samples[14]**
A0430	Fixed Wing, One Way	All	65%	0
A0431	Rotary Wing, One Way	Northeast; South	-35%	0
A0431	Rotary Wing, One Way	Midwest; West	-73%	1
A0435	Fixed Wing, Per Mile	All	82%	0
A0436	Rotary Wing, Per Mile	All	0%[15]	1

The Issuer agreed with the Criticism #1.

Corrective Action:

The Issuer correctly recalculated the five QPAs using contracted rates rather than paid claims identified during the Audit. No further action is required with respect to the calculation of these five QPAs.

Conduct a self-audit of all air ambulance QPA calculations made and claims for air ambulance services furnished by a nonparticipating provider of air ambulance services, from January 1, 2022 through the date of this final report, to identify claims for which the reported QPA was higher than it should have been if calculated correctly. For those claims, refund to the consumer the cost-sharing differential amount owed based on the

[11] Geographic region identified by the Issuer, which in turn, based the geographic region on US Census Regions and national coverage. See 45 C.F.R. § 149.140(a)(7)(ii) for further details.
[12] Incorrectly calculated QPA percentage difference compares the difference between the incorrect QPA using 2019 paid claim amounts to the correct QPA using 2019 contracted rates. A positive number represents that the incorrect QPA was higher than it should have been, whereas a negative number represents that the incorrect QPA was lower than it should have been.
[13] The correct QPAs used in this comparison were provided by the Issuer prior to the court decision in *TMA III*.
[14] The impacted claims represent the number of claims for which the Issuer applied the wrong QPA for claims paid in 2022.
[15] CCIIO notes that while the QPA was accurate, the Issuer's QPA calculation methodology was incorrect.

lower correct QPA. For claims for which the reported QPA was lower than if calculated correctly, no action is recommended.

Plans and issuers are expected to calculate QPAs using a good faith, reasonable interpretation of the applicable statutes and regulations that remain in effect after the *TMA III* decision.[16] Additionally, CCIIO will use enforcement discretion under the relevant No Surprises Act provisions for any plan or issuer that uses a QPA calculated in accordance with the methodology under the July 2021 interim final rules and guidance in effect immediately before the decision in *TMA III* for items and services furnished before November 1, 2024.[17] This exercise of enforcement discretion applies to QPAs for purposes of patient cost sharing, providing required disclosures with an initial payment or notice of denial of payment, and providing required disclosures and submissions under the Federal IDR process.[18]

Within 45 calendar days of receipt of this final report, provide documents containing the results from the self-audit and any resulting cost-sharing differential amounts to CCIIO. The results should contain the claim numbers, dates of service, dates of the initial payment or notice of denial of payment, corrected QPAs, and amounts and dates of refund payments to consumers.

Issuer Response: The Company concurs with the draft final report ("Report") dated February 14, 2024.

- The Company implemented corrective actions for Finding 1. The five incorrect QPAs identified during the audit were correctly recalculated.
- The Company will complete the required self-audits for Finding 1 and provide the requested results within 45 days of receipt of the final report.

CCIIO concurs with the Issuer's position.

[16] FAQs About Consolidated Appropriation Act, 2021 Implementation Part 67 (May 1, 2024), available at https://www.cms.gov/files/document/faqs-part-67.pdf.
[17] *Id*.
[18] *Id*.

B. QPA Disclosure Requirements Findings

Violation of 45 C.F.R. §§ 149.140(d)(1)(i) and (iv).

CCIIO identified two findings related to these provisions in the following instances:

Finding 2 – Failing to provide a statement that, generally, the provider may initiate the IDR process within four (4) days after the end of the open negotiation period.

Plans and issuers are required to provide certain disclosures in a remittance advice sent with the initial payment or in a notice of denial of payment when the cost-sharing amount with respect to an item or service furnished by a nonparticipating provider of air ambulance services is calculated based on the QPA. These disclosures include a statement that if the provider or facility, as applicable, wishes to initiate a 30-day open negotiation period for purposes of determining the amount of total payment, the provider or facility may contact the appropriate person or office to initiate open negotiation, and that if the 30-day open negotiation period does not result in a determination, generally, the provider may initiate the IDR process within four days after the end of the open negotiation period. The Issuer failed to provide a statement containing the required disclosure with the initial payment or notice of denial of payment in violation of 45 C.F.R. § 149.140(d)(1)(iv).

On 06/22/2022, the Issuer received an air ambulance provider claim (Claim) with a service date of 06/03/2022. The Claim was subject to the No Surprises Act and the amount on which cost sharing was based was the QPA; therefore, the Issuer was required to provide a statement that generally the provider may initiate the IDR process within four days after the end of open negotiation period. On 06/29/2022, the Issuer provided a disclosure to a nonparticipating provider of air ambulance services that did not contain the required language.

On 11/05/2022, the Issuer reprocessed the Claim as shown in *RFI 10.27.2022_Reprocessed EOB (ETJMYMQF6)*. The reprocessed Claim contained a disclosure with revised language stating, “you have 4 business days beginning on the 31st business day following the conclusion of the Open Negotiation period to initiate the independent resolution process.” The revised language, however, remained non-compliant because it referred to the 31st business day following the conclusion and not the beginning of the Open Negotiation period.

The Issuer agreed with this finding addressed in Criticism #2.

Corrective Action:

Implement a system upgrade to update the non-compliant disclosure language to meet the requirements. For example, revised language could state,

- "… you have 4 business days following the conclusion of the Open Negotiation period to initiate the independent dispute resolution process."
- "… you have 4 business days beginning on the 1st business day following the conclusion of the Open Negotiation period to initiate the independent resolution process."
- "… you have 4 business days beginning on the 31st business day following the beginning/start of the Open Negotiation period to initiate the independent resolution process."

Conduct a self-audit of all claims for air ambulance services furnished by a nonparticipating provider of air ambulance services, from January 1, 2022 through the date of this final report, to identify any claims for which the Issuer failed to provide a compliant statement that, generally, the provider or facility may initiate the IDR process within four days after the end of the open negotiation period.

Within 45 calendar days of receipt of this final report, provide documentation of the system upgrade reflecting compliant disclosure language and the results from the self-audit to CCIIO. The results should contain the claim numbers, dates of service, and dates of the notice of initial payment or denial of payment.

Issuer Response: The Company concurs with the draft final report ("Report") dated February 14, 2024.

- The Company implemented corrective actions for Finding 2. The NSA disclosures that appear on the Company's Explanation of Benefits (EOB) for NSA-eligible claims was updated on 12/8/2023 to include the following statement: *"You have 4 business days following the conclusion of the Open Negotiation period to initiate the independent resolution process."*
- The Company will complete the required self-audits for Finding 2 and provide the requested results, along with documentation for Finding 2, within 45 days of receipt of the final report.

CCIIO concurs with the Issuer's position.

Finding 3 – Failing to provide the QPA with an initial payment or notice of denial of payment.

Plans and issuers are required to provide certain disclosures with the initial payment or notice of denial of payment when the cost sharing amount with respect to an item or service furnished by a nonparticipating provider of air ambulance services is calculated based on the QPA. These disclosures include sharing the QPA. The Issuer failed to share the QPA with the initial payment of one claim in violation of 45 C.F.R. § 149.140(d)(1)(i).

In Call Letter Item #4a, CCIIO requested the Issuer's claims data for items and services for which the requirement to apply a QPA applies. Relying upon the Issuer's representations, in *CL-4a_QPA Claim Data File*, CCIIO requested "all documentation" demonstrating compliance with the No Surprises Act which included QPA disclosures for each applicable item or service. The Issuer's production included one air ambulance claim with two line items which did not include QPAs as required.

CCIIO requested that the Issuer provide a narrative describing why the Issuer was not in compliance with QPA disclosure requirements and the corrective actions taken by the Issuer to come into compliance. In *RFI-1_QPA Disclosures*, the Issuer stated that, "it has been compliant with the QPA disclosure requirements pursuant to 45 C.F.R. § 149.140(d) since the legislation was enacted on 1/1/2022." The Issuer further explained, "While there is not a stand-alone field on the Explanation of Benefits (EOB) containing the explicit amount, the QPA can be readily determined from the information provided on the EOB by performing a simple calculation."

In response to CCIIO's inquiry, the Issuer modified the language on its EOB to explain how the QPA is derived. According to *RFI-1_QPA Disclosures*, on 05/26/2022, the Issuer modified the disclosure to include the following statement:

The QPA is the difference between the "submitted charges" and "not payable" amount shown on each covered service line.

Additionally, on 07/25/2022, the Issuer provided the following corrective action:

> To further enhance our QPA disclosure, the Company has initiated discussions with various internal stakeholders and business owners to explore a system enhancement to display the QPA in a stand-alone field on provider EOBs. This is a complex enhancement involving multiple system applications and platforms. The Information Technology (IT) team and system developers are working together to define the system requirements that will be needed to enhance the

EOBs. We are targeting to complete this part of the process by 8/1/2022, at which time we have previously committed to providing CMS with additional details.

On 11/05/2022, the Issuer reprocessed the Claim as shown in *RFI 10.27.2022_Reprocessed EOB (ETJMYMQF6)*. The Issuer revised the Claim's EOB to include, "QPA" in its "ALLOWABLE AMOUNT" field. By revising the EOB to clearly identify the QPA, the Issuer's disclosure was compliant.

The Issuer agreed with this finding addressed in Criticism #3.

Corrective Action:

The Issuer implemented a system upgrade which included adding a QPA field to all disclosures provided with initial payments and notices of denial of payment for items and services for which the QPA applies, reprocessed the one claim identified during the Audit that was impacted by this finding, and shared the QPA with the nonparticipating provider of air ambulance services. No further action is required with respect to the identified claim.

Conduct a self-audit of all claims for air ambulance services furnished by a nonparticipating provider of air ambulance services, from January 1, 2022 through the date of this final report, to identify any claims for which the cost-sharing amount was required to be calculated based on the QPA and for which the Issuer failed to share the QPA in a remittance advice sent with an initial payment or notice of denial of payment. Within 45 calendar days of receipt of this final report, provide documentation containing the results from the self-audit to CCIIO. The results should contain the claim numbers, dates of service, and dates of the initial payment or notice of denial of payment.

Issuer Response: The Company concurs with the draft final report ("Report") dated February 14, 2024.

- The Company implemented corrective actions for Finding 3. A field displaying the QPA was added to the Company's EOB on 11/3/2022.
- The Company will complete the required self-audits for Finding 3 and provide the requested results within 45 days of receipt of the final report.

CCIIO concurs with the Issuer's position.

C. QPA Calculation Methodology Requirements Observation

Observation related to compliance with the explanation in the rule preamble regarding which contracts to take into account when determining the median contracted rate under 45 C.F.R. §§ 149.140(b)(1) and (c)(1)

CCIIO identified an observation of these provisions in the following instances:

Observation 1 – Failing to calculate the QPA in accordance with then-applicable rules by excluding contracted rates for contracts under which no claims were filed.

CCIIO reviewed the Issuer's policies and procedures for calculating QPAs as well as the Issuer's complete list of QPAs for air ambulance service calculations made and claims for air ambulance services furnished by a nonparticipating provider of air ambulance services during the Audit Period. CCIIO determined that the Issuer did not properly calculate QPAs as described in the preamble discussion in the Requirements Related to Surprise Billing; Part I (86 FR 36872) that was subsequently vacated by the court decision in TMA III. The Issuer excluded contracted rates for air ambulance services recognized by the Issuer on January 31, 2019, that were not billed during the Audit Period.

Preamble discussion outlined in Requirements Related to Surprise Billing; Part I (86 FR 36872) defines contracted rate. In particular, the preamble notes, "The No Surprises Act envisions that each contracted rate for a given item or service be treated as a single data point when calculating a median contracted rate. Therefore, if a plan or issuer has a contract with a provider group or facility, the rate negotiated with that provider group or facility under the contract is treated as a single contracted rate, if the same rate applies to all providers of such provider group or facility under the single contract. *Likewise, the rate negotiated under a contract constitutes a single contracted rate regardless of the number of claims paid at that contracted rate.* …." (Emphasis added).

The issuer excluded contracted rates if there were no claims associated with that rate in contradiction to the preamble discussion. However, the court decision in TMA III vacated this part of the contract rate provision.

V. Closing

QPA Calculation Methodology Requirements Findings: All air ambulance QPAs, impacting four HCPCS codes, were reviewed as part of this Audit. Of these, there was one finding with five occurrences.

- The Issuer's QPA calculation methodology incorrectly used claim payment amounts instead of contracted rates and counted each claim as its own contracted rate, even when the claims were for the same item or service and submitted by the same provider of air ambulance services. There were five occurrences.

QPA Disclosure Requirements Findings: All air ambulance claims, totaling one claim, were reviewed as part of this Audit. From this claim, there were two findings and one occurrence associated with each finding.

- The Issuer failed to provide either a statement itself or compliant statement that, generally, the provider or facility may initiate the IDR process within four days after the end of open negotiation period. There was one occurrence.
- The Issuer failed to share the QPA with an initial payment or notice of denial of payment. There was one occurrence.

QPA Calculation Methodology Requirements Observations: All air ambulance QPAs, impacting four HCPCS codes, were reviewed as part of this Audit. Of these, there was one observation with five occurrences.

- The Issuer failed to calculate the QPA in accordance with then-applicable rules by excluding contracted rates for contracts under which no claims were filed. There were five occurrences.

VI. Audit Report Submission

The courtesy and cooperation extended by the officers and employees of the Issuer during the course of the Audit are hereby acknowledged.

Jeffrey C. Wu -S

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In addition, the following individuals participated in this Audit and in the preparation of this report:

Center for Consumer Information and Insurance Oversight

- Cynae DeRose, MPPA, MJ, MBA
- Mary Nugent, Director, CIE, FLMI, AIRC, MCM, ACS

Examination Resources, LLC