
PCP Contracting Practices and Qualified Payment Amount Calculation Under the No Surprises Act

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Executive Summary

The qualifying payment amount (QPA) is a calculation used to determine individual cost sharing for items and services covered by balance-billing protections under the No Surprises Act (NSA). The QPA is defined as the median in-network contracted rate recognized by a plan for the same or similar service that is furnished by a provider in the same or similar specialty, and in the same geographic region. The QPA is impacted by all contracts, regardless of how frequently a service is rendered. However, public plans such as Medicare Advantage or Medicaid managed care plans, are not included in any insurance market for purposes of determining the QPA.

To assess the extent to which a QPA may be impacted by including rates from low or no volume contracts in the calculation, Avalere Health surveyed individuals involved in contracting at primary care practices to solicit information on whether they contract with insurers for specialized services they rarely or never provide, whether those services include anesthesia, emergency services, or advanced imaging, and if they actively negotiate the rates for such services they rarely or never provide.

Key Findings

- Many primary care providers (PCPs), who significantly outnumber other specialties, are contracting with insurers for services the providers rarely or never provide.
- Most PCPs who rarely or never provide certain services do not actively negotiate payment rates for those services.
- The existence of PCP contracted rates for services rarely or never provided could cause the QPA to provide an inaccurate representation of the rates commonly paid for services rendered.

Background and Objective

QPA Background

A surprise medical bill occurs when insured patients are issued unexpected medical invoices after receiving medical care from out-of-network (OON) providers. In December 2020, Congress sought to address the issue of surprise medical bills by passing the NSA. The NSA was included in the Consolidated Appropriations Act of 2021 and went into effect on January 1, 2022. The law defines surprise bills as bills patients receive from providers who are outside of their health plan's network after receiving emergency care or when seeking services at an in-network facility.¹

¹ Centers for Medicare & Medicaid Services. "No Surprises Act: Overview of rules & fact sheets." <https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets> (accessed June 1, 2022).

The NSA protects insured patients from receiving surprise bills for most emergency services, regardless of whether those services were rendered by an OON provider.¹ The law includes provisions to determine the amount the health plan will pay the provider when the plan and provider do not agree on the payment amount. The same requirements apply when a patient schedules care at an in-network facility and is treated by an OON provider, unless the OON provider obtains the patient's consent to waive the requirement.² The law establishes the basis for patient cost-sharing liability, provider payment, and an independent dispute resolution (IDR) process for determining OON provider payment in instances where a rate is not agreed upon.

Congress debated including a benchmark or standard for determining payment rates to OON providers or facilities during the drafting of the legislation. However, a benchmark was ultimately not included in the law, and the resolution of a final payment rate was left to arbitration.³ Determining patient cost sharing often requires knowledge of the underlying payments from insurers to providers, for example, when a plan includes coinsurance.⁴ In the absence of a mandated payment rate, a methodology is customarily needed to calculate patient cost sharing in the scenarios impacted by the law.

To determine patient cost-sharing amounts in the scenarios protected under the law, the NSA introduced a new term, Qualifying Payment Amount (QPA). The law specifies that the QPA will be used to determine patient cost sharing in many scenarios.⁵ Interim final regulations implementing the NSA have defined QPA as a health plan's median contracted payment rate to providers in a given region. The NSA requires the QPA to be calculated based on rates for providers with the "same or similar specialty" and facility type; however, the interim final regulations provide health plans with the flexibility to define specialties based on their own contracting practices and to calculate separate QPAs per specialty "where the plan or issuer otherwise varies its contracted rates based on provider specialty"⁶. While the interim final rule aims for an "apples-to-apples" comparison of rates, stakeholders have expressed concerns that the administration did not clearly define what may be considered the "same or similar specialty" or articulate enforcement mechanisms for that nuance of the calculation.⁷

The interim final rules stated that the QPA must be a factor considered by an arbitrator during the IDR process for determining payment, and directed the arbitrator to choose the offer closest

2 Department of Health & Human Services. "HHS Announces Rule to Protect Consumers from Surprise Medical Bills." <https://www.hhs.gov/about/news/2021/07/01/hhs-announces-rule-to-protect-consumers-from-surprise-medical-bills.html> (accessed June 1, 2022).

3 Commonwealth Fund. "Summary of the No Surprises Act." https://www.commonwealthfund.org/sites/default/files/202101/Surprise_Billing_Law_Summary_v2_UPDATED_01-1920_21.pdf (accessed June 1, 2022).

4 Coinsurance definition: Cost sharing that is a percentage of the total amount the provider will be paid by beneficiaries.

5 "In cases where a specified state law applies, the recognized amount (the amount upon which cost sharing is based) and out-of-network rate for emergency and non-emergency services subject to the surprise billing protections is calculated based on such specified state law." Where there is no specified state law, the "QPA would apply to determine the recognized amount, and either an amount determined through agreement between the provider and issuer, or an amount determined by an IDR entity would apply to determine the out-of-network rate."

6 Requirements Related to Surprise Billing; Part I, 86 FR 36872, (July 13, 2021)

7 Regulations.gov "Requirements Related to Surprise Billing; Part I CMS-9909-IFC Display." <https://www.regulations.gov/docket/CMS-2021-0117/comments>. (accessed June 1, 2022).

to the QPA unless significant evidence is provided to indicate another amount is appropriate.⁸ Currently, regulatory provisions related to the QPA are being challenged in court in six different lawsuits across several states.⁹ Due to the suits, certain provisions, including the requirement that the IDR entity select the offer closest to the QPA, are currently vacated.¹⁰ The lawsuits are on hold pending updates to the rule, which are expected to be released in 2022.¹¹

Objectives

Avalere conducted a study to assess the impact of physician contracting practices for services rarely or never provided, and how contracted rates for services rarely or never provided may influence the QPA calculation.¹²

Survey Methodology

1. Approach

Avalere surveyed 75 primary care practice employees who have a role in contracting with insurers to capture key insights related to payer contracting practices. These surveys solicited information on whether those surveyed contract with insurers for services they rarely or never provide, as well as their negotiation practices related to these services. In the survey, the term “rarely” was defined as a service that is provided fewer than 2 times per year. Participants were asked if their primary practice negotiated reimbursement rates with commercial payers for anesthesia services, emergency services, and advanced imaging services.

2. Rationale

Primary care providers were selected for this survey because they outnumber other specific specialties when comparing total number of providers (Figure 2), and do not typically provide the specialized services of focus: anesthesiology, emergency medicine, and advanced imaging. As such, contracting practices within primary care offices may impact the QPA in ways not anticipated by policymakers when the QPA was defined. The survey questions were intended to provide insight into whether QPA for services that are rarely provided are influenced by such contracts and the degree of that impact.

8 “If a certified IDR entity does not choose the offer closest to the QPA, the written decision’s rationale must include a detailed explanation of the additional considerations relied upon, whether the information about those considerations submitted by the parties was credible, and the basis upon which the certified IDR entity determined that the credible information demonstrated that the QPA is materially different from the appropriate out-of-network rate.”

9 Keith, Katie. “The Six Provider Lawsuits Over The No Surprises Act: Latest Developments.” Health Affairs. February 16, 2022. <https://www.healthaffairs.org/doi/10.1377/forefront.20220216.824139/>

10 Vacated definition: to annul, set aside, or render void.

11 Keith, Katie. “Court Sets Aside Key Parts of No Surprises Act Rule.” Health Affairs. February 24, 2022. <https://www.healthaffairs.org/doi/10.1377/forefront.20220224.298748/>

12 The survey of primary care providers focused on scenarios impacted by the NSA.

3. Survey Questions

A list of 5 screening questions and 5 key survey questions was provided to guide survey participants and ensure response consistency. Questions articulated specific areas of rationale and targeted the collection of specific data/information related to:

- The type of organization to which a provider belongs (multi-practice provider group, independent practice, etc.), their position within the organization, and their role in negotiating reimbursement rates with commercial payers.
- Whether respondents generally contract for services they rarely or never provide.
- Whether PCPs' rate schedules include services likely to be provided in the scenarios covered by the NSA: anesthesiology, emergency medicine, and advanced imaging.
- Whether PCPs who contract for services they rarely or never provide negotiate those rates with insurers and if negotiation practices have shifted since 2019.

Key Findings

The majority (72%) of the 75 primary care professionals surveyed represented independent practices. Most of the survey respondents reported having a high level of authority in contracting decisions, with 37% of respondents identifying as independent decision makers. The second largest category of decision makers (33%) included respondents who make the final decision with input from staff.

According to survey results, most respondents do contract for services they rarely or never provide:

- 68% of respondents contract for services they rarely provide (i.e., services that are provided fewer than 2 times per year)
- 57% of respondents contract for services they never provide

Many PCPs contract for services typically provided by anesthesiologists, emergency physicians, or radiologists:

- 23% contract for anesthesiology services
- 59% contract for emergency services
- 56% contract for advanced imaging

Most survey respondents (41%) who contract for services they rarely or never provide do not actively negotiate the rates for those services, implying they accept the rates offered by insurers.

Discussion

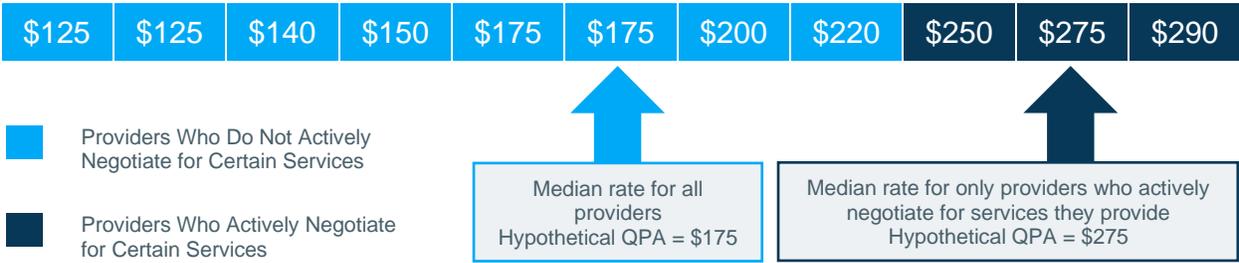
PCPs outnumber anesthesiologists, emergency physicians, and radiologists (Figure 1). The existence of PCP contract rates for services rarely or never provided may cause the QPA to reflect an inaccurate view of the rates commonly paid for in-network services. The inclusion of rates that are not actively negotiated may cause the QPA to be lower than the rates for some services in the market today.

Figure 1 — Total Number of Providers by Type¹³

Provider Type	Total Number of Providers
Primary Care Physicians	496,065
Anesthesiologists	51,282
Emergency Physicians	60,204
Radiologists	48,823

The illustration below (Figure 2) depicts a hypothetical example of a large number of non-negotiated rates for no/low volume procedures, (e.g., PCP rates) in the calculation of a QPA for an NSA-impacted service. In this example, there are a total of 11 rates included in the determination of the median for a QPA. The total is comprised of 8 rates that are not negotiated (e.g., from contracts with providers in other specialties who rarely or never provide the service) and 3 are negotiated rates from providers who regularly provide the service. The QPA changes depending on which providers are included in the calculation. If all providers are included, the QPA for the service would be \$175. When providers who rarely or never provide the service, and who therefore may not negotiate payment and accept a lower rate, are excluded, the QPA for the service would be \$275.

Figure 2 — Hypothetical Example of Contracted Service Rates¹⁴



13 Kaiser Family Foundation. “Professionally Active Physicians” and “Professionally Active Specialist Physicians by Field” QPA: Qualifying Payment Amount; IDR: Independent Dispute Resolution

14 The hypothetical illustration includes fictitious contracted service rates but serves to reflect where real data would be placed. The illustration depicts actual projections of the potential impact of contracted service rates on the QPA.



Consistent with this example, PCP rates could directly impact payments to anesthesiologists, radiologists, and emergency medicine physicians. While this study was limited to specific specialties, it may suggest larger implications. Furthermore, the effects of other recent policy initiatives that focus on contracted rates, such as the Transparency in Coverage rule, may also be affected by the contracting practices explored in this research.

Conclusion

This analysis suggests that for QPA calculations, including rates for providers who rarely or never provide a service may lead to QPA values that do not reflect payments typically accepted by in-network providers. Using the example of anesthesiology, emergency medicine, and advanced imaging services, the majority of primary care practices have contracted rates for these services that they never or rarely provide and that they do not negotiate with payers.

When policymakers consider methodologies to approximate market rates, approaches that include contracted rates for providers who rarely or never provide a service may result in estimated values that are not reliable estimates of real-world payment rates. If policymakers aim to approximate market rates, approaches that incorporate utilization rates could mitigate unintended consequences of the contracting practices identified in this research.

About Us

A healthcare consulting firm for more than 20 years, Avalere Health partners with leading life sciences companies, health plans, providers, and investors to bring innovative, data-driven solutions to today's most complex healthcare challenges. For more information, please contact info@avalere.com. You can also visit us at avalere.com.

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