Final Report: Federal Targeted Market Conduct Examination of

The Metropolitan Nashville Public Schools Group Health Plan for Certificated Employee & Retirees

As of July 23, 2024

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I. Scope of Examination

The Center for Consumer Information and Insurance Oversight (CCIIO) conducted a targeted Market Conduct Examination (Examination) of The Metropolitan Nashville Public Schools Group Health Plan for Certificated Employees & Retirees (Plan), a self-funded, non-Federal governmental plan, pursuant to 45 C.F.R. § 150.313, based on complaints submitted to CCIIO.

The Examination period was January 1, 2022 through November 30, 2022 (Examination Period). The purpose of the Examination was to assess the Plan's compliance with the Federal requirements under section 2799A-1(a) of the Public Health Service Act (PHS Act) and the following implementing regulations:

- 45 C.F.R. § 149.110 – Preventing Surprise Medical Bills for Emergency Services; and
- 45 C.F.R. § 149.140(d) – Information to be Shared About Qualifying Payment Amount (QPA).

CCIIO contracted with Examination Resources, LLC to assist CCIIO with conducting this Review.

During this Examination, CCIIO requested information, records, and data related to claims submitted to the Plan for emergency services furnished to Plan participants and beneficiaries. CCIIO requests included:

- Electronic claim records for the claims associated with the 96 complaints submitted to CCIIO; and
- For each complaint, the Explanation of Payment (EOP) (also known as provider remittances), and any other document the Plan used to convey required QPA disclosures to nonparticipating providers or emergency facilities with an initial payment or notice of denial of payment.

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 Examination 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 acceptance of such practices.

Please note: this report describes the Plan's compliance during the Examination Period with applicable regulations and guidance as modified by *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), which

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was issued by the United States District Court for the Eastern District of Texas after completion of CCIIO's examination of the Plan. The ruling vacated certain provisions of the regulations and guidance regarding the calculation of the QPA. The court's decision did not impact the findings or scope of this Examination.

The Examination and testing methodologies followed standards established by the National Association of Insurance Commissioners[1] and procedures developed by CCIIO. The Examination's claim sample was comprised of 96 complaints submitted to CCIIO and which alleged non-compliance with the requirements cited above. The claim sample is summarized in the table below:

Area Reviewed	Population	Sample Size
Complaints submitted to CCIIO	96	96

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

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II. Plan Profile

The Metropolitan Nashville Public Schools Group Health Plan for Certificated Employees & Retirees is a school district that serves Nashville and Davidson County, Tennessee. Metropolitan Nashville Public Schools offers self-funded health benefits to its retirees, employees and dependents.

Metropolitan Nashville Public Schools contracts with Cigna Health and Life Insurance Company (Cigna) as its third-party administrator to process claims.

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III. Executive Summary

CCIIO conducted the Examination to assess the Plan's compliance with the following requirements under Title XXVII of the PHS Act:

- Section 2799A-1(a) of the PHS Act – Preventing Surprise Medical Bills;
- 45 C.F.R. § 149.110 – Preventing Surprise Medical Bills for Emergency Services; and
- 45 C.F.R. § 149.140(d) – Information to be Shared About Qualifying Payment Amount (QPA).

The Examination Period was January 1, 2022 through November 30, 2022.

The Examination included the review and analysis of information, records and claims data. The claim sample totaled 96 claims. All items and services were for emergency services.

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 Examination are omitted from this report if no findings are indicated. Please note: all statutes and regulations cited in this report refer to those applicable during the Examination Period. In summary, findings were identified in violation of the following Federal requirements:

Finding 1	
Summary	Failing to send to the provider or facility an initial payment or a notice of denial of payment, not later than 30 calendar days after the bill for emergency services provided by a nonparticipating provider or a nonparticipating emergency facility is transmitted by the provider or facility. This 30-calendar-day period begins on the date the Plan receives the information necessary to decide a claim for payment for the services.
Citation(s)	Section 2799A-1(a)(1)(C)(iv)(I) of the PHS Act; 45 C.F.R. § 149.110(b)(3)(iv)(A)
Corrective Action	The Plan is directed to update its claim processing procedures to ensure that all initial payments or notices of denial of payment for emergency services covered under the Plan are sent to the nonparticipating provider or nonparticipating emergency facility no later than 30 calendar days after the bill for services is transmitted. This 30-calendar-day period

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	begins on the date the Plan receives the information necessary to decide a claim for payment for the services. The Plan is also directed to review its policies and procedures to ensure they comply with the requirement to send all initial payments or notices of denial of payment for non-emergency services furnished by a nonparticipating provider subject to the No Surprises Act with respect to a visit at a participating health care facility to the provider or facility no later than 30 calendar days after the bill for services is transmitted. *See* section 2799A-1(b)(1)(C) of the PHS Act; 45 CFR 149.120(c)(3). Within 30 calendar days of receipt of this final report, provide a copy of the updated procedure(s) to CCIIO.

Finding 2	
Summary	Failing to provide required QPA disclosures to the provider or facility in cases in which the recognized amount with respect to an item or service is the QPA.
Citation(s)	Section 2799A-1(a)(2)(B)(ii) of the PHS Act; 45 C.F.R. § 149.140(d)(1)(i), (iii)-(v)
Corrective Action	The Plan is directed to update its claim processing procedures to ensure all required disclosures are provided to the provider or facility, as applicable, with an initial payment or notice of denial of payment. Within 30 calendar days of receipt of this final report, provide a copy of the updated procedure(s) to CCIIO.

Additional details regarding these findings are in the Examination Results section of this report.

The Examination identified practices that do not comply with Federal requirements, applicable during the Examination Period. The Plan is directed, within 30 calendar days of receipt of this final report, to take corrective action to demonstrate its ability and intention to conduct business in accordance with Federal requirements. CCIIO strongly recommends that the Plan apply the corrective actions outlined in this Examination Report, and share information about the corrective actions taken, as applicable, with any third-party administrator(s), regardless of situs or regulatory jurisdiction, for No Surprises Act-eligible claims.

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IV. Examination Results

A. Failing to Timely Send Initial Payment or Notice of Denial of Payment

Violation of section 2799A-1(a)(1)(C)(iv)(I) of the PHS Act, as implemented at 45 C.F.R. § 149.110(b)(3)(iv)(A)

Plans and issuers must send an initial payment or a notice of denial of payment, no later than 30 calendar days after the bill is transmitted for emergency services that were provided by a nonparticipating provider or a nonparticipating emergency facility. This 30-calendar-day period begins on the date the Plan receives the information necessary to decide a claim for payment for the services.

CCIIO identified a violation of this provision in the following instances:

Finding 1 – The Plan failed to send an initial payment or a notice of denial of payment, no later than 30 calendar days after the bill was transmitted for emergency services.

CCIIO identified eight occurrences within the claims reviewed for which the Plan sent an initial payment or the notice of denial of payment for covered emergency services to the provider or facility later than 30 calendar days after the bill was transmitted by the provider or facility and the Plan had received the information necessary to decide a claim for payment for the services.

Corrective Action:

The Plan is directed to update its claim processing procedures and/or its claims handling process to ensure that an initial payment or notice of denial of payment is sent to the provider or facility not later than 30 calendar days after the bill for emergency services covered under the Plan is transmitted by the provider or facility. The 30-calendar-day period begins on the day the Plan receives the information necessary to decide a claim for payment for the services. The Plan is also directed to review its policies and procedures to ensure that they comply with the requirement to send all initial payments or notices of denial of payment for non-emergency services subject to the No Surprises Act furnished by a nonparticipating provider with respect to a visit at a participating health care facility to the provider or facility no later than 30 calendar days after the bill for services is submitted. Within 30 calendar days of receipt of this final report, provide a copy of the updated procedure(s) to CCIIO.

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Plan Response:

The Plan respectfully disagrees with the number of occurrences listed in the April 23, 2024 Draft Report of the Targeted Market Conduct Examination of The Metropolitan Nashville Public Schools Health Benefit Plan.

For all samples listed in Exhibit 1 of the Draft Report, the "number of Days Out of Compliance" appears to be based on the date of bank settlement rather than the date the Plan processed the claim and issued initial payment.

When accounting for the Plan's issuance of payment information to the bank the Number of Days Out of Compliance should be reduced by two (2) days for each sample. As a result, Samples #40 and #57 were processed for initial payment on the 30th calendar day and therefore not out of compliance.

CCIIO Response:

CCIIO accepts the Plan's response and has removed two of the original ten occurrences. Additionally, we have adjusted the number of days of compliance for the remaining violations.

B. Failing to Provide certain required QPA Disclosures with an Initial Payment or Notice of Denial Payment.

Violation of section 2799A-1(a)(2)(B)(ii) of the PHS Act, as implemented at 45 C.F.R. § 149.140(d)(1)(i), (iii)-(v)

Plans and issuers must make certain disclosures about the QPA with each initial payment or notice of denial of payment and provide certain additional information in a timely manner upon request of the provider or facility. This information must be provided in writing, either on paper or electronically, to a nonparticipating provider, facility, or provider of air ambulance services, as applicable, when the QPA serves as the recognized amount.

CCIIO identified a violation of this provision in the following instances:

Finding 2 – The Plan failed to provide certain required QPA disclosures with an initial payment or notice of denial of payment.

CCIIO identified 103 occurrences in which the Plan failed to provide certain required QPA disclosures. CCIIO determined the following violation occurred where required disclosures were not provided:

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- The QPA for each item or service involved, in violation of 45 C.F.R. § 149.140(d)(1)(i): 34 occurrences;

- Certification that the QPA applies for purposes of the recognized amount, in violation of 45 C.F.R. § 149.140(d)(1)(iii)(A): 21 occurrences;

- Certification that each QPA shared with the provider or facility was determined in compliance with 45 C.F.R. § 149.140, in violation of 45 C.F.R. § 149.140(d)(1)(iii)(B): 21 occurrences;

- A statement advising how to initiate a 30-day open negotiation period and a statement that the provider or the facility, generally, may initiate the Independent Dispute Resolution (IDR) process within four days after the end of the open negotiation period, in violation of 45 C.F.R. § 149.140(d)(1)(iv): 21 occurrences; and

- Contact information, including a phone number and email address, for the appropriate person or office to initiate open negotiations, in violation of 45 C.F.R. § 149.140(d)(1)(v): six occurrences.

CCIIO received and reviewed 96 complaints and electronic claim records submitted to the Plan. CCIIO determined that the violations occurred due to different factors, which included procedures that excluded QPAs from certain claim processing results. In many cases, these violations occurred in two key scenarios: (1) when the Plan did not issue an initial payment because the services were subject to a deductible greater than or equal to the QPA (and therefore the Plan should have sent a notice of denial of payment); and (2) for when claims had both paid and denied claim lines.

Corrective Action:

The Plan is directed to update its claim processing procedures and claims system, as applicable, to ensure that all required disclosures are provided with each initial payment or notice of denial of payment for all applicable No Surprises Act eligible claims. Within 30 calendar days of the receipt of this final report, provide a copy of the updated procedure(s) and an explanation as to why these violations occurred and an explanation of any system updates needed to address the violations to CCIIO.

Plan Response:

The Plan respectfully disagrees with the number of occurrences listed in Exhibit 2 of the Draft Report. As outlined below, the Plan provided the required information indicated to be missing for certain claims/Samples.

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"Missing QPA(s)"

The claim sample documentation provided for Samples #6, #12, 14, # 15, #21, #23, #29, #33, #34, #40, #41, #49, #51, #53, #57, #59, #60, #62, #63, #64, 65, #68, #74, #75, #81, #84, #88, and #91, representing thirty-four (34) of the sixty-eight (68) missing disclosure occurrences, includes the required Qualifying Payment Amount Disclosure.

Each of the Samples listed above represents a partially paid claim, as noted in Exhibit 2 of the Draft Report: "[*] Partially paid claim. One (1) or more service line(s) denied due to the following: The submitted Procedure is Disallowed Because it is Incidental To a Code Billed on the same Date of Service."

The codes not listed on the QPA disclosure were appropriately denied because reimbursement for the services billed on the claim was already remitted as part of Cigna's payment on other claim lines for the customer's care, in line with CMS, HCPCS and AMA coding guidelines.

CCIIO Response:

CCIIO accepts the Plan's response and has removed 34 of the original 68 missing QPA disclosure occurrences.

Plan Response:

"Missing Notice of Option 30-Day Neg/4-Day IDR"

The documentation provided by the Plan for Samples #7, #9, #11 and #58 includes a statement informing providers of the applicability of the federal dispute resolution process. This disclosure can be found in Remark Code language on the final page of the documentation for these samples and states: "FEDERAL LAW PROHIBITS BALANCE BILLING. PROVIDER: FEDERAL DISPUTE RESOLUTION PROCESS APPLIES – CONTACT CIGNA."

"Missing Contact Info"

For samples #11 and #14, the documentation provided includes contact information, including a telephone number and email address, for a provider to initiate open negotiations for purposes of determining an amount of payment (including cost sharing) for such item or service.

Please refer to the Remark Code language on the final page of the documentation submitted for Samples #11 and #14, which includes the statement: "FEDERAL LAW

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PROHIBITS BALANCE BILLING. PROVIDERS SHOULD CONTACT ZELIS AT NSA@ZELIS.COM OR 888.346.84.88 WITH QUESTIONS."

CCIIO Response:

CCIIO disagrees with the Plan's position on both the "Missing Notice of *Option* 30-day Neg/4-Day IDR" and "Missing Contact Info." The disclosures in the remark codes identified by the Plan do not comply with the requirements under the PHS Act and its implementing regulations because the language provided does not include the following: the required 30-day open negotiation period notice along with the information on initiating IDR and contact information for initiating open negotiation as 45 CFR 149.140(d)(1)(iv) and (v) require. As part of the corrective action to update its claim processing procedures to ensure that all required disclosures are included with each initial payment or notice of denial of payment for all applicable No Surprises Act eligible claims, the Plan is required to update the language that meets the requirements outlined in regulation. For example, revised language could state:

- "The Federal No Surprises Act (NSA) applies for this claim. The qualifying payment amount (QPA) applies for purposes of the recognized amount. Each QPA was determined in compliance with the NSA. Under the NSA, if you do not accept this initial payment amount, you have 30 business days from receipt of the initial payment or notice of denial of payment to initiate open negotiation. You may initiate open negotiation by contacting [email] or [phone number]. If no agreement is reached during the Open Negotiation, you have 4 business days following the conclusion of the Open Negotiation period to initiate the independent dispute resolution process."
- The Federal No Surprises Act (NSA) applies for this claim. For services rendered that were not air ambulance services, the qualifying payment amount (QPA) applies for purposes of the recognized amount. For air ambulance services rendered, the QPA applies for calculating the member cost share. The QPA for each item or service included on this notice was determined in compliance with the NSA. If you wish to initiate a 30-day open negotiation period for purposes of determining the amount of total payment of the claims in this notice you have 30 business days from receipt of the initial payment or notice of denial of payment to initiate a 30-day open negotiation period. You may initiate open negotiation by contacting [email] or [phone number]. If no agreement is reached during the 30-day open negotiation period for purposes of determining the amount of total payment of claims at issue, you may initiate the independent dispute resolution process within 4 business days beginning on the 1st business day following the conclusion of the open negotiation period."

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V. Closing

CCIIO conducted an Examination of the Plan based on 96 complaints submitted to CCIIO. CCIIO used these complaints as the claim samples for the Examination. CCIIO reviewed claim samples and identified two findings that totaled 111 occurrences.

Findings included:

- Failing to send the provider or facility an initial payment or a notice of denial of payment not later than 30-calendar days after the bill for the emergency services provided by a nonparticipating provider or a nonparticipating emergency facility is transmitted: eight occurrences; and

- Failing to provide required disclosures regarding the QPA with an initial payment or a notice of denial of payment: 103 occurrences.

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VI. Examination Report Submission

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

Jeff Wu,
Deputy Director, Policy
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services

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

- Center for Consumer Information and Insurance Oversight
- Nicole McClain, MCM
- Examination Resources, LLC

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