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**GENERAL CAA COMPLIANCE INFORMATION**

As of January 1, 2022, a number of new regulatory mandates are in place that affect our clients. The Federal Government requires Self-Funded Health Benefit Plans to comply with the below measures and places the burden of responsibility on the Plan Sponsor.

As your partner in self-funding, Allegiance has developed a number of solutions to help our clients maintain compliance. Additional fees will apply for some of these solutions in order to cover the administrative cost to Allegiance. The fees simply represent a pass-through cost for administration and new processing requirements for certain types of claims and allow us to support our clients in complying with these new regulations.

Clients who have a compliant alternative solution to any of the below regulatory issues may opt out of the Allegiance solution if the client attests in writing that the proposed alternative complies with the applicable mandate.

**What new services are required of Plan Sponsors?**

Allegiance is prepared to provide the following services to our clients to help them ensure compliance with the new federal regulations required of Self-Funded Plan Sponsors:

- **Machine-Readable Files** – As part of the Transparency in Coverage regulation, Self-Funded Health Plans must publicly disclose their in-network rates, and out-of-network allowed amounts and billed charges in a Machine-Readable File (MRF). Allegiance will provide a link for clients to post on their own internal sites. Additional fees may apply depending on the network(s) accessed by the Health Plan.
- **Qualified Payment Amount & Arbitration Process** – The Consolidated Appropriation Act (CAA) mandates that Self-Funded Health Plans pay a regulated “Qualified Payment Amount” for certain out-of-network services including, but not limited to: air ambulance services, non-network emergency room services, and non-network providers of a network hospital for which a patient has no choice (such as assistant surgeons and anesthesiology). The specific QPA allowable is calculated according to federal rules. Pricing disputes, negotiations, and mediation are also governed under the federal regulation. Depending on the Health Plan’s current out-of-network arrangements, additional fees will apply for some or all of these services.
- **Revised ID Card Requirements** – Effective for Plan Years beginning on or after January 1, 2022, Self-Funded Health Plans must provide ID Cards that include cost share information. Allegiance has already made the necessary adjustments to all current client ID Cards. That said, these regulations or other new regulations may impact the information included on ID Cards. Any time an ID Card reprint is needed due to changes in regulations or other compliance changes, the costs for the reprint will be passed through to the Plan Sponsor.



- **Updated Provider Directories** – Provider directories will be updated regularly every three (3) months and every two (2) days for any provider who terminates from the network. This will include all networks managed by Allegiance. For ancillary networks contracted with a Health Plan, that network will be responsible for maintaining their own directories.
- **Continuity of Care Services** – Effective January 1, 2022, a member must be able to receive services at in-network coverage levels for specified medical and behavioral conditions when a health care provider leaves a health plan's network. This regulation requires a number of actions by Allegiance to assist with client compliance, including identifying affected members across all applicable networks, sending notices to identified members, and facilitating appropriate clinical review of requested exceptions. Allegiance coordinates the necessary member notices and review of Continuity of Care exceptions on behalf of our Self-Funded clients. Additional fees apply for these services.
- **Mental Health Parity NQTL Survey** – Effective February 10, 2021, Self-Funded Health Plans are required to annually survey their NQTL mental health benefits for compliance. This is an additional requirement beyond the existing Mental Health Parity testing. A per survey fee will apply.
- **Reporting on Pharmacy Benefits and Drug Cost** – Effective December 27, 2022, Self-Funded Health Plans are required to submit data related to prescription drug and health care expenditures to the Federal Government. As Allegiance is not a Pharmacy Benefit Manager, we will not be providing this information directly. If Allegiance holds the PBM contract on behalf of our clients, we will help coordinate with the PBM.
- **Transparency in Coverage Self-Service Tool** – Effective January 1, 2023, Self-Funded Health Plans are required to make price comparison information available to participants, beneficiaries and enrollees through an internet-based self-service tool and in paper form, upon request. Allegiance will have a tool available to our clients that satisfies this compliance requirement. An additional PEPM fee will apply for access to the tool to defray Allegiance's costs for development and maintenance of the tool.
- **Advanced EOBs** – Subject to final regulations being issued including a final effective date, Allegiance intends to provide compliant advanced EOBs.

### **When do these new requirements become effective?**

Qualified Payment Amount process (QPA): January 1, 2022 for calendar year plans or first day of the first plan year after January 1, 2022 for non-calendar year plans

Updated ID Card Cost Sharing Language: January 1, 2022 for calendar year plans or first day of the first plan year after January 1, 2022 for non-calendar year plans

Continuity of Care Services: January 1, 2022 for calendar year plans or first day of the first plan year after January 1, 2022 for non-calendar year plans

Mental Health NQTL Surveys: February 10, 2021

Machine Readable Files (MRF): July 1, 2022



Reporting on Pharmacy Benefits and Drug Cost: Reporting for years 2020 and 2021 data is required by December 27, 2022

Transparency in Coverage Self-Service Tool: Effective January 1, 2023

## **MACHINE READABLE FILES**

### **When does this requirement become effective?**

July 1, 2022

### **What are the fees for Machine Readable Files (MRF)?**

There is a fee equal to \$100/month for Allegiance to provide the MRF applicable to your network arrangement.

### **Where will the MRFs be posted?**

Machine Readable Files will be posted to a secure location on the Allegiance website and clients will be provided information on how to link that website to the client's public facing website. Each client will have to discuss with their PBM vendor on how to access pharmacy information.

### **Why is there a fee for CSN/Montana MRFs?**

Significant customization work is required of the Allegiance Network team to prepare accurate and timely MRFs on behalf of clients with certain network designs. The quoted costs reflect only our costs for preparing, posting, and monitoring these files.

### **How will this fee be billed?**

The monthly fee (if applicable) will be billed to our clients through your monthly fixed cost bill.

## **QUALIFIED PAYMENT AMOUNT (QPA) / NO SURPRISES ACT (NSA)**

### **When does this requirement become effective?**

January 1, 2022 for calendar year plans or first day of the first plan year after January 1, 2022 for non-calendar year plans

### **What is involved in the QPA process?**

Federal law mandates that Self-Funded Health Plans pay a regulated "Qualified Payment Amount" (QPA) for certain out-of-network services. On behalf of our clients, Allegiance coordinates identification of QPA claims and repricing of QPA claims in partnership with our vendors.

As part of the regulation, providers can dispute a QPA determination. Allegiance, in partnership with Multiplan, will coordinate this dispute and the related arbitration process on behalf of our clients.

### **Which claims qualify for QPA?**

Federal law has identified certain out-of-network services for the QPA process including, but not limited to:

- Air Ambulance Services



- Non-network emergency services (in the event of medical emergencies)
- Non-network providers performing services at network hospitals for which a patient has no choice

### **What is the QPA?**

The QPA allowable is calculated according to Federal Rules and is based on currently accepted rates for a specific geography.

### **What are the fees for QPA administration?**

QPA determination is provided by Multiplan. A fee equal to 13% of savings is applied to applicable QPA claims.

If providers dispute the applied QPA, costs related to the initial dispute process are included in the 13% of savings charge. Situations that escalate to the regulated mediation process will be charged an additional per case administration fee and an independent dispute resolution (IDR) entity fee (IDR fee will be refunded to the prevailing party at the conclusion of IDR process). The amounts for these fees are set by the Federal Government and will be applied to the applicable claims. The Plan Sponsor is responsible for any additional reimbursements owed to the provider resulting from mediation determinations as well as the costs for the mediation itself if the provider prevails in the mediation.

For negotiations resulting from a dispute, Multiplan is authorized to allow up to 120% of the QPA in an attempt to avoid the additional expense of the mediation process.

### **How will the QPA fees be billed?**

Any QPA fees will be billed through the claims feed.

## **CONTINUITY OF CARE SERVICES**

### **When are the Continuity of Care requirements effective?**

January 1, 2022 for calendar year plans or first day of the first plan year after January 1, 2022 for non-calendar year plans

### **What are the Continuity of Care requirements in the CAA?**

A member must be able to receive services at in-network coverage levels for specified medical and behavioral conditions when a health care provider leaves a health plan's network. This regulation requires a number of actions by Allegiance to assist with our client's compliance, including identifying affected members across all applicable networks, sending notices to identified members, and facilitating appropriate clinical review of requested exceptions.

### **How will Allegiance manage the Continuity of Care requirements on behalf of its clients?**

Self-Funded Health Plans must send a notice to each impacted member upon learning of a provider termination from the network. Allegiance manages these mailings on behalf of our clients.

If a member returns the letter to request a Continuity of Care exception, Allegiance will manage these transition exceptions according to the regulation.



### **What are the fees for the Continuity of Care administration provided by Allegiance?**

The mailing of notification letters to impacted members will be charged to the Plan Sponsor for a fee of \$12/letter. This fee will be reviewed and adjusted annually to ensure it is reflective of our administrative costs.

If a member requests a Continuity of Care exception, an hourly fee is assessed based on the level of clinical review required: \$100/hr for RN review, \$275/hr for Physician review.

### **How are the Continuity of Care fees billed?**

The hourly review fees will be billed through the claims feed.

## **MENTAL HEALTH PARITY NQTL SURVEY**

### **When are the requirements for the NQTL Survey effective?**

February 1, 2021

### **What is the NQTL Survey Requirement?**

Self-Funded health Plans are required to annually survey their NQTL mental health benefits for compliance. Allegiance is able to provide these surveys to our clients for a per survey fee upon request.

### **What is the fee for Allegiance to provide the NQTL surveys?**

Allegiance will provide the surveys for a fee of \$250 per survey upon request.

### **How are the NQTL survey fees billed?**

The per survey fee is billed through your monthly fixed cost bill.

## **Transparency in Coverage Self Service Tool**

### **When does this requirement become effective?**

This information must be available for plan years beginning on or after January 1, 2023 with respect to the 500 items and services listed in the Transparency in Coverage final rules. Information for all covered items and services must be available for plan years beginning on or after January 1, 2024.

### **What are the Transparency in Coverage Self Service Tool Requirements?**

Self-Funded Health Plans are required to make price comparison information available to participants, beneficiaries, and enrollees through an internet-based self-service tool and in paper form, upon request. Future guidance is expected to clarify whether compliance with the internet-based self-service tool requirements of the Transparency in Coverage Final Rules also satisfy the analogous requirements set forth in the No Surprises Act Price Comparison Tools regulation.

Allegiance is working with a vendor partner to develop a tool that will satisfy our clients' responsibilities regarding the Transparency in Coverage Self Service tool. This tool will be available to clients for an additional fixed cost fee to defray Allegiance's costs for development and maintenance of the tool.



**What is the fee for the Allegiance TiC Self Service Tool?**

Costs for the proposed tool have not been finalized. Our goal is to make it as cost-effective as possible for our clients. It will be a PEPM fee and will be communicated in detail to clients prior to any billing for the fee.

**How will the TiC Self Service Tool fee be billed?**

The PEPM fee for the TiC Self Service Tool will be billed through your monthly fixed cost bill.