

§ 149.140 Methodology for calculating qualifying payment amount.

(a) *Definitions.* For purposes of this section, the following definitions apply:

(1) *Contracted rate* means the total amount (including cost sharing) that a group health plan or health insurance issuer has contractually agreed to pay a participating provider, facility, or provider of air ambulance services for covered items and services, whether directly or indirectly, including through a third-party administrator or pharmacy benefit manager. Solely for purposes of this definition, a single case agreement, letter of agreement, or other similar arrangement between a provider, facility, or air ambulance provider and a plan or issuer, used to supplement the network of the plan or coverage for a specific participant, beneficiary, or enrollee in unique circumstances, does not constitute a contract.

(2) *Derived amount* has the meaning given the term in § 147.210 of this subchapter.

(3) *Eligible database* means—

(i) A State all-payer claims database; or

(ii) Any third-party database which—

(A) Is not affiliated with, or owned or controlled by, any health insurance issuer, or a health care provider, facility, or provider of air ambulance services (or any member of the same controlled group as, or under common control with, such an entity). For purposes of this paragraph (a)(3)(ii) (A), the term controlled group means a group of two or more persons that is treated as a single employer under sections 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986, as amended;

(B) Has sufficient information reflecting in-network amounts paid by group health plans or health insurance issuers offering group or individual health insurance coverage to providers, facilities, or providers of air ambulance services for relevant items and services furnished in the applicable geographic region; and

(C) Has the ability to distinguish amounts paid to participating providers and facilities by commercial payers, such as group health plans and health insurance issuers offering group or individual health insurance coverage, from all other claims data, such as amounts billed by nonparticipating providers or facilities and amounts paid by public payers, including the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of the Social Security Act (or a demonstration project under title XI of the Social Security Act), or the Children's Health Insurance Program under title XXI of the Social Security Act.

(4) *Facility of the same or similar facility type* means, with respect to emergency services, either —

(i) An emergency department of a hospital; or

(ii) An independent freestanding emergency department.

(5) *First coverage year* means, with respect to an item or service for which coverage is not offered in 2019 under a group health plan or group or individual health insurance coverage offered by a health insurance issuer, the first year after 2019 for which coverage for such item or service is offered under that plan or coverage.

(6) *First sufficient information year* means, with respect to a group health plan or group or individual health insurance coverage offered by a health insurance issuer—

(i) In the case of an item or service for which the plan or coverage does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section in 2019, the first year after 2022 for which the plan or issuer has sufficient information to calculate the median of such contracted rates in the year immediately preceding that first year after 2022; and

(ii) In the case of a newly covered item or service, the first year after the first coverage year for such item or service with respect to such plan or coverage for which the plan or issuer has sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section in the year immediately preceding that first year.

(7) *Geographic region* means—

(i) For items and services other than air ambulance services—

(A) Subject to paragraphs (a)(7)(i)(B) and (C) of this section, one region for each metropolitan statistical area, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in a State, and one region consisting of all other portions of the State.

(B) If a plan or issuer does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an item or service provided in a geographic region described in paragraph (a)(7)(i)(A) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in the State, and one region consisting of all other portions of the State.

(C) If a plan or issuer does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an item or service provided in a geographic region described in paragraph (a)(7)(i)(B) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in each Census division and one region consisting of all other portions of the Census division, as described by the U.S. Census Bureau.

(ii) For air ambulance services—

(A) Subject to paragraph (a)(7)(ii)(B) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in the State, and one region consisting of all other portions of the State, determined based on the point of pick-up (as defined in 42 CFR 414.605).

(B) If a plan or issuer does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an air ambulance service provided in a geographic region described in paragraph (a)(7)(ii)(A) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in each Census division and one region consisting of all other portions of the Census division, as described by the U.S. Census Bureau, determined based on the point of pick-up (as defined in 42 CFR 414.605).

(8) *Insurance market* is, irrespective of the State, one of the following:

(i) The individual market (other than short-term, limited-duration insurance or individual health insurance coverage that consists solely of excepted benefits).

(ii) The large group market (other than coverage that consists solely of excepted benefits).

(iii) The small group market (other than coverage that consists solely of excepted benefits).

(iv) In the case of a self-insured group health plan, all self-insured group health plans (other than account-based plans, as defined in § 147.126(d)(6)(i) of this subchapter, and plans that consist solely of excepted benefits) of the same plan sponsor, or at the option of the plan sponsor, all self-insured group health plans administered by the same entity (including a third-party administrator contracted by the plan), to the extent otherwise permitted by law, that is responsible for calculating the qualifying payment amount on behalf of the plan.

(9) *Modifiers* mean codes applied to the service code that provide a more specific description of the furnished item or service and that may adjust the payment rate or affect the processing or payment of the code billed.

(10) *Newly covered item or service* means an item or service for which coverage was not offered in 2019 under a group health plan or group or individual health insurance coverage offered by a health insurance issuer, but that is offered under the plan or coverage in a year after 2019.

(11) *New service code* means a service code that was created or substantially revised in a year after 2019.

(12) *Provider in the same or similar specialty* means the practice specialty of a provider, as identified by the plan or issuer consistent with the plan's or issuer's usual business practice, except that, with respect to air ambulance services, all providers of air ambulance services are considered to be a single provider specialty.

(13) *Same or similar item or service* means a health care item or service billed under the same service code, or a comparable code under a different procedural code system.

(14) *Service code* means the code that describes an item or service using the Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS), or Diagnosis-Related Group (DRG) codes.

(15) *Sufficient information* means, for purposes of determining whether a group health plan or health insurance issuer offering group or individual health insurance coverage has sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section—

(i) The plan or issuer has at least three contracted rates on January 31, 2019, to calculate the median of the contracted rates in accordance with paragraph (b) of this section; or

(ii) For an item or service furnished during a year after 2022 that is used to determine the first sufficient information year—

(A) The plan or issuer has at least three contracted rates on January 31 of the year immediately preceding that year to calculate the median of the contracted rates in accordance with paragraph (b) of this section; and

(B) The contracted rates under paragraph (a)(15)(ii)(A) of this section account (or are reasonably expected to account) for at least 25 percent of the total number of claims paid for that item or service for that year with respect to all plans of the sponsor (or the administering entity as provided in paragraph (a)(8)(iv) of this section, if applicable) or all coverage offered by the issuer that are offered in the same insurance market.

(16) *Qualifying payment amount* means, with respect to a sponsor of a group health plan or health insurance issuer offering group or individual health insurance coverage, the amount calculated using the methodology described in paragraph (c) of this section.

(17) *Underlying fee schedule rate* means the rate for a covered item or service from a particular participating provider, providers, or facility that a group health plan or health insurance issuer uses to determine a participant's, beneficiary's, or enrollee's cost-sharing liability for the item or service, when that rate is different from the contracted rate.

(18) *Downcode* means the alteration by a plan or issuer of a service code to another service code, or the alteration, addition, or removal by a plan or issuer of a modifier, if the changed code or modifier is associated with a lower qualifying payment amount than the service code or modifier billed by the provider, facility, or provider of air ambulance services.

(b) *Methodology for calculation of median contracted rate*—(1) *In general*. The median contracted rate for an item or service is calculated by arranging in order from least to greatest the contracted rates of all group health plans of the plan sponsor (or the administering entity as provided in paragraph (a)(8)(iv) of this section, if applicable) or all group or individual health insurance coverage offered by the issuer in the same insurance market 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 and provided in the geographic region in which the item or service is furnished and selecting the middle number. If there are an even number of contracted rates, the median contracted rate is the average of the middle two contracted rates. In determining the median contracted rate, the amount negotiated under each contract is treated as a separate amount. 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 has a contract 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).

(2) *Calculation rules.* In calculating the median contracted rate, a plan or issuer must:

(i) Calculate the median contracted rate with respect to all plans of such sponsor (or the administering entity as provided in paragraph (a)(8)(iv) of this section, if applicable) or all coverage offered by such issuer that are offered in the same insurance market;

(ii) Calculate the median contracted rate using the full contracted rate applicable to the service code, except that the plan or issuer must—

(A) Calculate separate median contracted rates for CPT code modifiers “26” (professional component) and “TC” (technical component);

(B) For anesthesia services, calculate a median contracted rate for the anesthesia conversion factor for each service code;

(C) For air ambulance services, calculate a median contracted rate for the air mileage service codes (A0435 and A0436); and

(D) Where contracted rates otherwise vary based on applying a modifier code, calculate a separate median contracted rate for each such service code-modifier combination;

(iii) In the case of payments made by a plan or issuer that are not on a fee-for-service basis (such as bundled or capitation payments), calculate a median contracted rate for each item or service using the underlying fee schedule rates for the relevant items or services. If the plan or issuer does not have an underlying fee schedule rate for the item or service, it must use the derived amount to calculate the median contracted rate; and

(iv) Exclude risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments.

(3) *Provider specialties; facility types.* (i) If a plan or issuer has contracted rates that vary based on provider specialty for a service code, the median contracted rate is calculated separately for each provider specialty, as applicable.

(ii) If a plan or issuer has contracted rates for emergency services that vary based on facility type for a service code, the median contracted rate is calculated separately for each facility of the same or similar facility type.

(c) *Methodology for calculation of the qualifying payment amount—(1) In general.* (i) For an item or service (other than items or services described in paragraphs (c)(1)(iii) through (vii) of this section) furnished during 2022, the plan or issuer must calculate the qualifying payment

amount by increasing the median contracted rate (as determined in accordance with paragraph (b) of this section) for the same or similar item or service under such plans or coverage, respectively, on January 31, 2019, by the combined percentage increase as published by the Department of the Treasury and the Internal Revenue Service to reflect the percentage increase in the CPI-U over 2019, such percentage increase over 2020, and such percentage increase over 2021.

(A) The combined percentage increase for 2019, 2020, and 2021 will be published in guidance by the Internal Revenue Service. The Department of the Treasury and the Internal Revenue Service will calculate the percentage increase using the CPI-U published by the Bureau of Labor Statistics of the Department of Labor.

(B) For purposes of this paragraph (c)(1)(i), the CPI-U for each calendar year is the average of the CPI-U as of the close of the 12-month period ending on August 31 of the calendar year, rounded to 10 decimal places.

(C) The combined percentage increase for 2019, 2020, and 2021 will be calculated as:

$(\text{CPI-U } 2019 / \text{CPI-U } 2018) \times (\text{CPI-U } 2020 / \text{CPI-U } 2019) \times (\text{CPI-U } 2021 / \text{CPI-U } 2020)$

(ii) For an item or service (other than items or services described in paragraphs (c)(1)(iii) through (vii) of this section) furnished during 2023 or a subsequent year, the plan or issuer must calculate the qualifying payment amount by increasing the qualifying payment amount determined under paragraph (c)(1)(i) of this section, for such an item or service furnished in the immediately preceding year, by the percentage increase as published by the Department of the Treasury and the Internal Revenue Service.

(A) The percentage increase for any year after 2022 will be published in guidance by the Internal Revenue Service. The Department of the Treasury and Internal Revenue Service will calculate the percentage increase using the CPI-U published by the Bureau of Labor Statistics of the Department of Labor.

(B) For purposes of this paragraph (c)(1)(ii), the CPI-U for each calendar year is the average of the CPI-U as of the close of the 12-month period ending on August 31 of the calendar year, rounded to 10 decimal places.

(C) The combined percentage increase for any year will be calculated as $\text{CPI-U present year} / \text{CPI-U prior year}$.

(iii) For anesthesia services furnished during 2022, the plan or issuer must calculate the qualifying payment amount by first increasing the median contracted rate for the anesthesia conversion factor (as determined in accordance with paragraph (b) of this section) for the same or similar item or service under such plans or coverage, respectively, on January 31, 2019, in accordance with paragraph (c)(1)(i) of this section (referred to in this section as the indexed median contracted rate for the anesthesia conversion factor). The plan or issuer must then multiply the indexed median contracted rate for the anesthesia conversion factor by the sum of the base unit, time unit, and physical status modifier units of the participant, beneficiary, or enrollee to whom anesthesia services are furnished to determine the qualifying payment amount.

(A) The base units for an anesthesia service code are the base units for that service code specified in the most recent edition (as of the date of service) of the American Society of Anesthesiologists Relative Value Guide.

(B) The time unit is measured in 15-minute increments or a fraction thereof.

(C) The physical status modifier on a claim is a standard modifier describing the physical status of the patient and is used to distinguish between various levels of complexity of the anesthesia services provided, and is expressed as a unit with a value between zero (0) and three (3).

(D) The anesthesia conversion factor is expressed in dollars per unit and is a contracted rate negotiated with the plan or issuer.

(iv) For anesthesia services furnished during 2023 or a subsequent year, the plan or issuer must calculate the qualifying payment amount by first increasing the indexed median contracted rate for the anesthesia conversion factor, determined under paragraph (c)(1)(iii) of this section for such services furnished in the immediately preceding year, in accordance with paragraph (c)(1)(ii) of this section. The plan or issuer must then multiply that amount by the sum of the base unit, time unit, and physical status modifier units for the participant, beneficiary, or enrollee to whom anesthesia services are furnished to determine the qualifying payment amount.

(v) For air ambulance services billed using the air mileage service codes (A0435 and A0436) that are furnished during 2022, the plan or issuer must calculate the qualifying payment amount for services billed using the air mileage service codes by first increasing the median contracted rate (as determined in accordance with paragraph (b) of this section), in accordance with paragraph (c)(1)(i) of this section (referred to in this section as the indexed median air mileage rate). The plan or issuer must then multiply the indexed median air mileage rate by the number of loaded miles provided to the participant, beneficiary, or enrollee to determine the qualifying payment amount.

(A) The air mileage rate is expressed in dollars per loaded mile flown, is expressed in statute miles (not nautical miles), and is a contracted rate negotiated with the plan or issuer.

(B) The number of loaded miles is the number of miles a patient is transported in the air ambulance vehicle.

(C) The qualifying payment amount for other service codes associated with air ambulance services is calculated in accordance with paragraphs (c)(1)(i) and (ii) of this section.

(vi) For air ambulance services billed using the air mileage service codes (A0435 and A0436) that are furnished during 2023 or a subsequent year, the plan or issuer must calculate the qualifying payment amount by first increasing the indexed median air mileage rate, determined under paragraph (c)(1)(v) of this section for such services furnished in the immediately preceding year, in accordance with paragraph (c)(1)(ii) of this section. The plan or issuer must then multiply the indexed median air mileage rate by the number of loaded miles provided to the participant, beneficiary, or enrollee to determine the qualifying payment amount.

(vii) For any other items or services for which a plan or issuer generally determines payment for the same or similar items or services by multiplying a contracted rate by another unit value, the plan or issuer must calculate the qualifying payment amount using a methodology that is similar to the methodology required under paragraphs (c)(1)(iii) through (vi) of this section and reasonably reflects the payment methodology for same or similar items or services.

(2) *New plans and coverage.* With respect to a sponsor of a group health plan or health insurance issuer offering group or individual health insurance coverage in a geographic region in which the sponsor or issuer, respectively, did not offer any group health plan or health insurance coverage during 2019—

(i) For the first year in which the group health plan, group health insurance coverage, or individual health insurance coverage, respectively, is offered in such region—

(A) If the plan or issuer has sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section, the plan or issuer must calculate the qualifying payment amount in accordance with paragraph (c)(1) of this section for items and services that are covered by the plan or coverage and furnished during the first year; and

(B) If the plan or issuer does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an item or service provided in a geographic region, the plan or issuer must determine the qualifying payment amount for the item or service in accordance with paragraph (c)(3)(i) of this section.

(ii) For each subsequent year the group health plan, group health insurance coverage, or individual health insurance coverage, respectively, is offered in the region, the plan or issuer must calculate the qualifying payment amount by increasing the qualifying payment amount determined under this paragraph (c)(2) for the items and services furnished in the immediately preceding year, in accordance with paragraph (c)(1)(ii), (iv), or (vi) of this section, as applicable.

(3) *Insufficient information; newly covered items and services.* In the case of a plan or issuer that does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section in 2019 (or, in the case of a newly covered item or service, in the first coverage year for such item or service with respect to such plan or coverage if the plan or issuer does not have sufficient information) for an item or service provided in a geographic region

(i) For an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for the item or service with respect to the plan or coverage), the plan or issuer must calculate the qualifying payment amount by first identifying the rate that is equal to the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in the year immediately preceding the year in which the item or service is furnished (or, in the case of a newly covered item or service, the year immediately preceding such first coverage year) determined by the plan or issuer, respectively, through use of any eligible database, and then increasing that rate by the percentage increase in the CPI-U over such preceding year. For purposes of this section, in cases in which an eligible

database is used to determine the qualifying payment amount with respect to an item or service furnished during a calendar year, the plan or issuer must use the same database for determining the qualifying payment amount for that item or service furnished through the last day of the calendar year, and if a different database is selected for some items or services, the basis for that selection must be one or more factors not directly related to the rate of those items or services (such as sufficiency of data for those items or services).

(ii) For an item or service furnished in a subsequent year (before the first sufficient information year for such item or service with respect to such plan or coverage), the plan or issuer must calculate the qualifying payment amount by increasing the qualifying payment amount determined under paragraph (c)(3)(i) of this section or this paragraph (c)(3)(ii), as applicable, for such item or service for the year immediately preceding such subsequent year, by the percentage increase in CPI-U over such preceding year;

(iii) For an item or service furnished in the first sufficient information year for such item or service with respect to such plan or coverage, the plan or issuer must calculate the qualifying payment amount in accordance with paragraph (c)(1)(i), (iii), or (v) of this section, as applicable, except that in applying such paragraph to such item or service, the reference to 'furnished during 2022' is treated as a reference to furnished during such first sufficient information year, the reference to 'in 2019' is treated as a reference to such sufficient information year, and the increase described in such paragraph is not applied; and

(iv) For an item or service furnished in any year subsequent to the first sufficient information year for such item or service with respect to such plan or coverage, the plan or issuer must calculate the qualifying payment amount in accordance with paragraph (c)(1)(ii), (iv), or (vi) of this section, as applicable, except that in applying such paragraph to such item or service, the reference to 'furnished during 2023 or a subsequent year' is treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

(4) *New service codes.* In the case of a plan or issuer that does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section and determine the qualifying payment amount under paragraphs (c)(1) through (3) of this section because the item or service furnished is billed under a new service code—

(i) For an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for the item or service with respect to the plan or coverage), the plan or issuer must identify a reasonably related service code that existed in the immediately preceding year and—

(A) If the Centers for Medicare & Medicaid Services has established a Medicare payment rate for the item or service billed under the new service code, the plan or issuer must calculate the qualifying payment amount by first calculating the ratio of the rate that Medicare pays for the item or service billed under the new service code compared to the rate that Medicare pays for the item or service billed under the related service code, and then multiplying the ratio by the qualifying payment amount for an item or service billed under the related service code for the year in which the item or service is furnished.

(B) If the Centers for Medicare & Medicaid Services has not established a Medicare payment rate for the item or service billed under the new service code, the plan or issuer must calculate the qualifying payment amount by first calculating the ratio of the rate that the plan or issuer reimburses for the item or service billed under the new service code compared to the rate that the plan or issuer reimburses for the item or service billed under the related service code, and then multiplying the ratio by the qualifying payment amount for an item or service billed under the related service code.

(ii) For an item or service furnished in a subsequent year (before the first sufficient information year for such item or service with respect to such plan or coverage or before the first year for which an eligible database has sufficient information to calculate a rate under paragraph (c)(3)(i) of this section in the immediately preceding year), the plan or issuer must calculate the qualifying payment amount by increasing the qualifying payment amount determined under paragraph (c)(4)(i) of this section or this paragraph (c)(4)(ii), as applicable, for such item or service for the year immediately preceding such subsequent year, by the percentage increase in CPI-U over such preceding year;

(iii) For an item or service furnished in the first sufficient information year for such item or service with respect to such plan or coverage or the first year for which an eligible database has sufficient information to calculate a rate under paragraph (c)(3)(i) of this section in the immediately preceding year, the plan or issuer must calculate the qualifying payment amount in accordance with paragraph (c)(3) of this section.

(d) *Information to be shared about qualifying payment amount.* In cases in which the recognized amount with respect to an item or service furnished by a nonparticipating provider, nonparticipating emergency facility, or nonparticipating provider of air ambulance services is the qualifying payment amount, the plan or issuer must provide in writing, in paper or electronic form, to the provider or facility, as applicable—

(1) With each initial payment or notice of denial of payment under § 149.110, § 149.120, or § 149.130:

(i) The qualifying payment amount for each item or service involved;

(ii) If the qualifying payment amount is based on a downcoded service code or modifier—

(A) A statement that the service code or modifier billed by the provider, facility, or provider of air ambulance services was downcoded;

(B) An explanation of why the claim was downcoded, which must include a description of which service codes were altered, if any, and a description of which modifiers were altered, added, or removed, if any; and

(C) The amount that would have been the qualifying payment amount had the service code or modifier not been downcoded;

(iii) A statement to certify that, based on the determination of the plan or issuer—

(A) The qualifying payment amount applies for purposes of the recognized amount (or, in the case of air ambulance services, for calculating the participant's, beneficiary's, or enrollee's cost sharing); and

(B) Each qualifying payment amount shared with the provider or facility was determined in compliance with this section;

(iv) 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 negotiation period does not result in a determination, generally, the provider or facility may initiate the independent dispute resolution process within 4 days after the end of the open negotiation period; and

(v) Contact information, including a telephone number and email address, for the appropriate person or office to initiate open negotiations for purposes of determining an amount of payment (including cost sharing) for such item or service.

(2) In a timely manner upon request of the provider or facility:

(i) Information about whether the qualifying payment amount for items and services involved included contracted rates that were not on a fee-for-service basis for those specific items and services and whether the qualifying payment amount for those items and services was determined using underlying fee schedule rates or a derived amount;

(ii) If a plan or issuer uses an eligible database under paragraph (c)(3) of this section to determine the qualifying payment amount, information to identify which database was used; and

(iii) If a related service code was used to determine the qualifying payment amount for an item or service billed under a new service code under paragraph (c)(4)(i) or (ii) of this section, information to identify the related service code; and

(iv) If applicable, a statement that the plan's or issuer's contracted rates include risk-sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments for the items and services involved (as applicable) that were excluded for purposes of calculating the qualifying payment amount.

(e) *Certain access fees to databases.* In the case of a plan or issuer that, pursuant to this section, uses an eligible database to determine the qualifying payment amount for an item or service, the plan or issuer is responsible for any costs associated with accessing such database.

(f) *Audits.* The procedures described in part 150 of this subchapter apply with respect to ensuring that a plan or coverage is in compliance with the requirement of applying a qualifying payment amount under this subpart and ensuring that such amount so applied satisfies the requirements under this section, as applicable.

(g) *Applicability date.* The provisions of this section are applicable for plan years or in the individual market, policy years beginning on or after January 1, 2022, except that paragraph (a) (18) of this section regarding the definition of the term “downcode” and paragraph (d)(1)(ii) of this section regarding additional information that must be provided if the qualifying payment amount is based on a downcoded service code or modifier are applicable with respect to items or services provided or furnished on or after October 25, 2022, for plan years or in the individual market, policy years beginning on or after January 1, 2022.

[86 FR 36970, July 13, 2021, as amended at 87 FR 52652, Aug. 26, 2022]