



July 10, 2023

The Honorable Bill Cassidy, MD
Ranking Member
Senate Health, Education, Labor, and Pensions Committee
428 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Ranking Member Cassidy:

On behalf of our members, the American College of Emergency Physicians (ACEP) and the Emergency Department Practice Management Association (EDPMA) would like to thank you and the staff of the Senate HELP Committee for allowing us to partake in the roundtable on June 29 regarding surprise medical billing and issues around implementation of the *No Surprises Act*.

Given the multitude of issues with implementation of the *No Surprises Act* mentioned in the HELP Roundtable, we offer the following summarized recommendations on the specific domains as requested, noting these have all previously been provided to the Departments (in some instances several times) as part of our effort to provide solutions as productive stakeholders. More detailed explanations of these recommendations follow in the attached.

Summary Recommendations

To ensure that patients continue to be kept out of the middle of billing disputes following out-of-network emergency care, and that a fair and efficient process to all parties can be followed, the Departments should:

- [Expand the scope of the IDR portal](#) to span the entire out-of-network process, beginning with the initiation of Open Negotiation and continuing all the way through remittance of accurate payment after an IDR payment determination has been rendered.
- [Reissue IDRE guidance to allow for batching](#) of items and services covered by self-insured plans beyond a single employer.
- [Release aggregated information about IDRE complaints](#) received on an at-minimum semiannual basis, including:
 - Total number of cases submitted;
 - Total number of cases that are resolved;
 - Total number of cases that are unresolved;
 - Most common issues raised (i.e., delay or lack of payment, parties being unresponsive to inquiries and initiation requests, etc) and how they were addressed (i.e., enforcement mechanism, etc); and
 - Best practices to avoid issues commonly leading to complaints.

- [Release a methodology of the elements used by CCIIO in audits](#), including which elements, if any, were considered but ultimately omitted from the audit.
- [Immediately scale back the 600% increase to the IDR administrative fee](#) and reinstate the 2022 rate.
 - Additionally, provide documentation of the cost assumptions made to increase the 2023 fee, an explanation for the inclusion of items in the calculation of the administrative fee that were actually described in the IDRE certification elements, and a statement regarding whether the Departments utilized the administrative fee as a mechanism to affect IDR utilization.
- [Require payment with penalties and interest accrued](#) for each day that either party refuses to pay the mandated IDRE entity fee, in order to further disincentivize insurers delaying its payment.
- [Require plans to use RARCs](#) when providing the initial payment or notice of denial in order to clarify state or federal eligibility for out-of-network dispute resolution, as well as reduce confusion and unnecessary administrative transactions and delays.
- Institute specific enforcement measures that apply to any party that does not comply with any requirements in the law or its implementing regulations. Work closely with state regulators to [establish a more comprehensive and responsive enforcement process](#) for physician groups to report compliance issues and receive a response and meaningful resolution within a designated timeframe.
- Require that the new, more comprehensive portal [include time-stamped submission by either party of proof of payment made for any amounts owed following an IDR decision](#) in order to empower enforcement and compliance with one of the *No Surprises Act's* most fundamental statutory requirements.

We appreciate the opportunity to provide potential solutions to help improve the implementation of the No Surprises Act. If you have any questions, please contact Laura Wooster, ACEP's Senior Vice President of Advocacy and Practice Affairs at lwooster@acep.org, or Cathey Wise, EDPMA's Executive Director at cathey.wise@edpma.org.

Sincerely,



Christopher S. Kang, MD, FACEP
ACEP President



Andrea Brault, MD, MMM, FACEP
Chair, EDPMA Board of Directors

Background on Emergency Medicine Patient Billing

Before discussing these recommendations in greater depth below, we would like to first note that aspects of how patient care billing works in emergency medicine are often confused with the realities of scheduled, non-emergency care. Because of the dynamics and realities of acute, unscheduled patient care, as well as the requirements of the Emergency Medical Treatment & Labor Act (EMTALA), emergency medicine groups do not collect billing or cost-sharing information prior to assessing and stabilizing the patient.

Administrative staff for pre-scheduled health care drill down to the patient's individual health plan type and pre-identify the correct co-pays, deductibles, and other pertinent benefit information, and, often, will require pre-payment of some or all patient-responsibility amounts, all before the patient even enters the exam room or treatment space. This type of information is critical for the federal dispute resolution process under the *No Surprises Act* – yet emergency medicine practices must wait until after the episode of care has occurred to attempt to obtain information on individual policy benefits, relying on costly and time-consuming administrative back-and-forth that may again involve the patient for more clarification (who often, will not know a sufficient level of detail, and must go back to the insurance plan, who does have the information).

Open Negotiation Recommendations

As per statutory requirements (45 CFR § 149.510(b)(1)), a party must send a notice to the other party (open negotiation notice) that includes information sufficient to identify the item(s) and service(s) (including the date(s) the item(s) or service(s) were furnished, the service code, and initial payment amount, if applicable), an offer of an out-of-network rate, and contact information for the party sending the open negotiation notice in writing within 30 business days beginning on the day the provider, facility, or provider of air ambulance services receives an initial payment or a notice of denial of payment from the plan or issuer regarding the item or service. However, health insurers rarely acknowledge receipt of the Open Negotiations notice or actively engage in negotiations. To address this (and other broader issues tied to the No Surprises Act implementation), ***the Departments should expand the scope of the IDR portal to span the entire out-of-network process, beginning with the initiation of Open Negotiation and continuing all the way through remittance of accurate payment after an IDR payment determination has been rendered.***

As part of this comprehensive portal, there should be an assigned identification number to specific items or services under dispute to better track them through the process, as well as timestamps for each step of the process that occurs. The updated portal should also clearly include the contact information, including the email addresses, for all the key contacts involved in the dispute. Finally, a robust portal would formalize the Open Negotiations Process and provide a more structured way for health insurers and providers to have certainty of when the 30-day Open Negotiations Process begins, share information, and try to resolve disputes before the IDR process. For example, if the Qualifying Payment Amount (QPA) and Remittance Advice Remark (RARC) codes were not shared by the health plan at the time of initial payment (as happens frequently), the Departments could require that information in the Open Negotiation process. It would also track the level of engagement by both health insurers and providers and provide more data to the Departments about the level of compliance among the disputing parties to the statutory and regulatory requirements.

Batching Requirements

Rules and requirements around batching are leading to significant confusion as well as an increase in the number of claims going through the IDR process (rather than the decrease in claims that batching was intended to produce). One of the major batching issues relates to “the same group health plan or health insurance issuer.” In the implementing regulations, the Departments repeat that items and services can be batched by “the same group health plan or health insurance issuer.”

Separately, the *No Surprises Act*, for purposes of establishing the QPA, defines “insurance markets,” as the individual market, the large group market, the small group market, and “in the case of a self-insured group health plan, other self-insured group health plans.” (*See*, 42 USC 300gg-111(a)(3)(E)(iv)(IV)). Federal regulation further references insurance market categories including, “all self-insured group health plans...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” (*See*, 29 CFR §2590.716-6(8)(a)).

Nowhere in the regulations did the Departments state that, for self-insured group health plans, batches must be restricted to an individual employer. Yet in the *Federal Guidance for Certified IDREs*, the Departments have added this restriction.¹

Interpreting statute to require that a batch for a self-insured plan is limited to that of single employer has rendered the batching section of the statute essentially meaningless. These criteria require providers to know the employer of a product, which is not a standard data element to the claims process and therefore often not available to emergency providers (whether in- or out-of-network). The Departments have also yet to issue regulations regarding plan or insurance identification cards as included in Sec. 107 of the *No Surprises Act* that might work to resolve these issues. This highlights the complications raised by attempting to restrict batching by an element that is not delineated in statute or regulation and is not a part of the current claims process. It is unreasonable to ask initiating parties to batch disputes based on an element to which they have no visibility, leading to confusion in and pressure on the IDR system. Therefore, ***we request that the Departments reissue IDRE guidance and allow for batching of items and services covered by self-insured plans beyond a single employer.*** This will ensure that the Congressional intent of the batching provisions is met and help reduce the strain on IDR overall by allowing multiple disputes to be resolved together where Department policies now require that eligible disputes move through the system individually or in very small quantities that do little to reduce the strain on the IDR system. Requiring health plans to provide the plan type at the time of the initial payment or notice of denial (one of our previous recommendations) would therefore also help reduce some of the errors in batching.

Further potential solutions to batching issues include removal of the same procedure code (i.e., CPT) barrier – the statute only limits batching by the “same item or service” but does not mandate the CPT code (or other coding system) restriction. Allowing like “items and services” (e.g., emergency evaluation and management services or all services received during an emergency department visit) to

¹ “Note that items and services paid for by different self-insured group health plans are not allowed to be batched.” *Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities* (March 2023) <https://www.cms.gov/files/document/federal-idr-guidance-idr-entities-march-2023.pdf>.

be batched will expand the universe of claims providers may be able to batch together, thus reducing administrative burdens on providers, plans, and the Administration.

Transparency Suggestions

Across all facets of the out-of-network dispute resolution process, transparency is severely lacking. Though many complaints about insurer violations in the process have been submitted by providers through the Administration's [official complaint submission mechanism](#), we are aware of very little engagement or response to these complaints, let alone meaningful resolution.

The primary mechanism for addressing noncompliance with the *No Surprises Act* appears to be on a case-by-case basis through the submission and resolution of individual complaints. ***The Departments should release on an at-minimum semiannual basis, aggregated information about these cases, including:***

- Total number of cases submitted;
- Total number of cases that are resolved;
- Total number of cases that are unresolved;
- Most common issues raised (i.e., delay or lack of payment, parties being unresponsive to inquiries and initiation requests, etc) and how they were addressed (i.e., enforcement mechanism, etc); and
- Best practices to avoid issues commonly leading to complaints.

This information should also be broken out by state to help provide more granular data and potentially answer some of the questions posed during the meeting about the possible reasons for geographic variation among IDR cases.

By moving to a more comprehensive portal as described in the Open Negotiation section above, the Administration will have a mechanism that allows for easy aggregation and reporting of this information.

Audits

Releasing all of this information will reduce the overall number of complaints and increase compliance of all *No Surprises Act* requirements. Further, analysis of these complaints could help determine which health insurers need to be proactively audited. Together with meaningful and effective enforcement, auditing is critical to ensuring that health insurers have an incentive to comply with the statutory and regulatory requirements.

Insufficient transparency exists around the audit of “good faith” QPA calculation in accordance with the letter and spirit of the law and related regulations. ***CCIIO should release a methodology of the elements used in the audits including which elements, if any, were considered but ultimately omitted from the audit.*** At a minimum, auditors should review a statistically valid sample size of a payers’ QPAs, to avoid cherry-picking or selection bias, and should require the entities calculating the QPA to provide:

- The number of contracts used to calculate the QPA;

- Whether the QPA was calculated using contracts with clinicians in the same or similar specialty;
- The geography used to calculate the QPA (i.e., Single MSA, all MSAs in a state, Census Division);
- Whether the plan or issuer’s QPA calculations have had an audit result of anything other than “clean” within the last 3 years; and
- If the plan or issuer uses contracts from a plan year other than January 31, 2019 to calculate the QPA.

Administrative Fees

For CY 2022, the Departments set the IDR administrative fee at \$50.² On October 31, 2022, the Center for Consumer Information and Insurance Oversight (CCIIO) announced that the Federal IDR administrative fee would remain \$50 for CY 2023.³ On December 23, 2022, CCIIO suddenly reversed course and increased the 2023 administrative fee had been revised from \$50 to \$350.⁴

The *No Surprises Act* states:

ADMINISTRATIVE FEE.—

“(A) IN GENERAL.—Each party to a determination under paragraph (5) to which an entity is selected under paragraph (3) in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the IDR process with respect to such determination in an amount described in subparagraph (B) for such year.

*“(B) AMOUNT OF FEE.—The amount described in this subparagraph for a year is an amount established by the Secretary in a manner such that the total amount of fees paid under this paragraph for such year is estimated to be **equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the IDR process**⁵(emphasis added).*

The Administration’s sevenfold increase in the nonrefundable fee must be paid by disputing parties to even access the Federal IDR process. This increase is a substantial obstacle for initiating parties to seek redress for unsubstantiated underpayments from health plans for services provided to insured patients, creating an artificial threshold for the IDR process—a barrier that Congress explicitly omitted from the statute despite several proposals for thresholds offered along the way. If claims are less than \$350 and cannot be batched together to exceed this threshold, it is actually *more* expensive to enter the

² CCIIO, Memorandum: *Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act* (September 30, 2021) (<https://www.hhs.gov/guidance/document/calendar-year-2022-fee-guidance-federal-independent-dispute-resolution-process-under-no>).

³ CCIIO, Memorandum: *Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act* (October 21, 2022) (<https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf/>).

⁴ CCIIO, Memorandum: *Amendment to the Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act: Change in Administrative Fee* (December 23, 2022) (<https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/amended-cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf>).

⁵ 26 U.S.C. §9816(c)(8); 29 U.S.C. §1135e(c)(8); 42 U.S.C. §300gg-111(c)(8)

IDR process than to adjudicate a low payment to a claim, thereby limiting what types of claims can go through the IDR process.

We are concerned that the rationale for the fees is outside the statutory basis for the fee, that the fee is being utilized to engineer reduced access to IDR rather than the stated statutory purpose, and that the fee is being levied on users of IDR to pay for services that the IDR entities entered contracts to provide.

In the December 23, 2022 memorandum, the Departments state that “*there is a significant backlog of disputes pending eligibility determinations before certified IDR entities which has continued to grow since the publication of the prior 2023 guidance. To address this issue, the Departments have engaged a contractor and government staff to conduct pre-eligibility reviews, which include outreach and technical assistance in support of the certified IDR entities’ eligibility determinations*” This rationale appears to defy the certifications that are required of IDR entities.

Further, in the second interim final rule, the Departments explicitly state that considerations related to the ability of and resources needed by IDRs to make payment determinations is the province of certified IDR entity fees, *not* the administrative fee:

*“The Departments will also consider the anticipated time and resources needed for certified IDR entities to meet the requirements of these interim final rules, such as the time and resources needed to obtain certification, making payment determinations (**including determining whether the dispute belongs in the Federal IDR process**), data reporting, and audits. The Departments will also consider factors such as the anticipated volume of payment determinations under the Federal IDR process and adequacy of the Federal IDR process capacity to efficiently handle the volume of IDR initiations and payment determinations. The Departments will review and update the allowable fee range annually based on these factors and the impact of inflation and other cost increases. The Departments seek comment on these factors and any additional factors that should be considered **when determining the range for allowable certified IDR entity fees**”⁶ (emphasis added).*

Thus, the Departments have explicitly stated that the costs it cites as a rationale for increasing the 2023 administrative fee should be carried by the certified IDR entities and, if appropriate, reflected in the certified IDR entity fees. Therefore, the assertion that this fee helps offset the cost of burden to certified IDR entities due to the massive amount of claims does not hold up. The non-refundable administrative fee is not disbursed to the entities; it is simply a pay-to-play fee given to CMS to engage in the IDR process. Furthermore, there is no transparency as to how the projected additional tens of millions of dollars (seven times more *per claim* going forward) being collected by CMS in administrative fees is being utilized.

The Departments should immediately address this by reinstating the 2022 rate. In addition, we request that the Departments provide documentation of the cost assumptions made to increase the 2023 fee, an explanation for the inclusion of items in the calculation of the administrative fee that were actually described in the IDRE certification elements, and a statement regarding whether the Departments utilized the administrative fee as a mechanism to affect IDR utilization.

⁶ 86 Fed. Reg. 56005 (October 7, 2021).

Communication with IDREs

There are significant issues with communication between parties in the IDR process and their certified IDRE. In many cases, the beginning of the IDR process is stalled because it is difficult to find the correct point of contact and indicate participation in the IDR process. Revamping the portal to allow for easy communication between parties and the IDRE assigned to their case will enhance the speed of the IDR process, limit confusion, and allow for retrospective review of the process when required.

Furthermore, we are aware that health insurers are refusing to pay certain fees associated with the IDR process and the decision of the IDRE. Currently, each party must pay the predetermined certified IDR entity fee charged by the certified IDR entity to the certified IDR entity at the time the parties submit their offer, which is refunded to the winner of the process. However, IDREs sometimes do not receive the initial fee from health insurers, delaying the ability for the IDRE to make their judgment (as well as allowing the insurers to continue to earn interest on the withheld money). Certified IDR entities should have a uniform process in place to collect all the IDR fees and then refund the winning party the certified IDR entity fee. ***The Departments should require payment and penalties, with interest accrued for each day that either party refuses to pay the entity fee, in order to further disincentivize their delaying payment of this mandated fee.***

State and Federal Eligibility

We continue to hear from parties and IDREs regarding struggles to determine whether state or federal rules apply to an out-of-network dispute. The Departments themselves have noted that such eligibility determination has been a major factor in the delayed adjudication and increased costs for tens of thousands of out-of-network claims. ***The Departments should require plans to use [RARCs](#) when providing the initial payment or notice of denial in order to clarify state or federal eligibility for out-of-network dispute resolution,*** as well as reduce confusion and unnecessary administrative transactions and delays. Ensuring the use of the RARCs for all claims will also give providers the necessary information to assess patient responsibility amounts, keep patients out of the middle of the process, and reduce the need to initiate payment disputes for out-of-network services in the first place.

RARCs already exist and are in common usage, so mandating their use should not necessitate any changes to the templates that health plans and issuers typically use to relay information about a claim to a provider. When health plans and issuers adjudicate claims and communicate information to the health care provider, they do so in a standardized format called an ANSI 835 (835) remittance. Health Insurance Portability and Accountability Act (HIPAA) transaction and code set (TCS) standards already require that health plans and users use ANSI Claims Adjustment Reason Code (CARC) and RARC for their 835 electronic healthcare transactions. There are enough fields on the standard 835 remittance to accommodate the *No Surprises Act* RARCs. The Departments should also begin the process of requesting a modification to the standard 835 remittance form so that all the information, including the qualifying payment amount (QPA), is disclosed in a uniform way.

Enforcement

ACEP and EDPMA have heard from many members that enforcement of the NSA's dispute resolution requirements has been lacking, including but not limited to plan failure to pay post-IDR decision, pay administrative fees, provide the QPA with the initial payment, etc.

As well, when such an enforcement issue is encountered by a physician group, there is no quick or reliable way to have the issue resolved. Part of the issue lies in the fact that much of the NSA's enforcement has been delegated to the states. While the NSA Help Desk and email addresses for provider questions are a helpful start, our members report that it often can take weeks and up to many months for them to receive confirmation of even just receipt of the request, much less if it is being addressed or resolved. Such delayed responses go against the spirit of the *No Surprises Act*, both in statute and implementation, which was set up with clear timelines and requirements. ***We ask that the Administration work closely with state regulators to establish a more comprehensive and responsive process for physician groups to report compliance issues and receive a response and a meaningful resolution within a designated timeframe.*** Given the criticality of the issues at stake, acknowledgment of the complaint should be same day, and meaningful resolution should be within 10 business days.

Timely Payment

We are alarmed by the growing trend of health insurers' failing to pay what they owe to the provider after a certified IDR entity makes a payment determination that results in a balance owed to the provider. Many health insurers are [simply not paying the amount owed](#) within the required 30-day period, *if at all*, despite numerous attempts by providers to collect the payment to which they are entitled under the terms of the dispute resolution. Numerous provider entities have reported that they have not received the amount owed to them in *over 90 percent* of the cases in which payment is due. Further, some provider entities have recovered some amounts, but those amounts do not accurately reflect the IDR entity's decision.

Most alarmingly, upon attempting to recover dollars owed after a payment determination, certain health plans have indicated *in writing* that they refuse to pay because they do not agree with the IDR entity's decision. Finally, some health plans are indicating that they are refusing to pay amounts owed after an IDR entity's payment determination because they later disagree with the IDR entity's federal eligibility determination. These assertions are occurring despite the health plan's refusal to provide RARC codes or other information that would clearly and proactively identify claims that are subject to the federal IDR process, as has been repeatedly requested by the provider community. **These instances of blatant disregard for the requirements under the law, which essentially neuter both the intent and the practical purpose of IDR process, point to a significant need for enforcement and consequences for noncompliance.**

In addition, to empower enforcement and compliance, the Departments should begin to require that the comprehensive portal described in previous sections should include time-stamped submission by either party of proof of payment made for any amounts owed following an IDR decision. This will allow for easier auditing and verification that these statutorily

mandated payments are being made and allow for more actionable enforcement when they are not. Health insurers who are not paying what they owe to a provider after the IDR process is completed must be penalized and forced to compensate the provider the total amount owed **plus interest and penalties**. Insurers continue to record profits quarter after quarter, and any delay or lack of payment of the amounts they owe to providers under the *No Surprises Act* allows them to continue to accrue substantial one-sided benefits including additional interest on the amounts owed, while cash-starving the providers who actually provide medical care to their members.