Emergency Department EDPMA Practice Management Association

No Surprises Act Implementation and Compliance

Data Analysis (April 2024)

EDPMA

The Emergency Department Practice Management Association (EDPMA) is the trade association for emergency medicine focused on the sustainable delivery of high-quality, cost-effective patient care in emergency departments. Our members see or support approximately 60% of essentially all annual emergency department visits.

The Study

EDPMA surveyed its membership to report on issues related to the implementation of the *No Surprises Act* since the statute went into effect on January 1, 2022. This data documents our members' actual experiences with the Independent Dispute Resolution (IDR) process and represents a summary of findings building upon two previous studies that were released in March 2023 and updated with additional data in July 2023.

Impact on Access to Care

EDPMA fully supports the *No Surprises Act* (NSA) as enacted and its goal of protecting patients from unanticipated medical expenses after receiving care from an out-of-network (OON) physician. To ensure a sustainable health care safety net, emergency physicians must be fairly compensated in a timely manner for services delivered to patients, especially given that all health care delivered in the emergency department setting is required under the Emergency Medical Treatment and Labor Act (EMTALA). EMTALA provides a critical safety net for patients to receive care in a medical emergency but there is no guarantee that providers delivering that care will be compensated for their services.

Together, EMTALA and the NSA protect patients and provide access to care. And both require adequate resources to ensure that access to health care services is sustained. However, because regulations have substantially altered the NSA's intended impact and health plans frequently do not comply with both the law and the regulations, the resources and cash flow of physician groups who staff emergency departments are severely hampered. This presents a significant risk for patient access to timely, high quality, and sustainable emergency care.

The Data

Survey respondents represent different regions and physician groups of different sizes and ownership models. These respondents shared data related to their experience with NSA implementation. Survey data includes Out-of-Network (OON) claims with dates of service from January 1 – December 31, 2023, which were eligible for submission to the federal IDR process.

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Reimbursement Changes in 2023

For Out-of-Network claims, physician groups experienced a **39% reduction in OON physician reimbursement** (net collections per ED visit) in 2023 compared to 2021.

39%

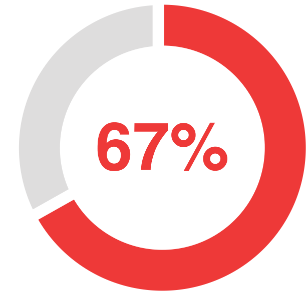
Decrease in OON physician reimbursement

WHAT THIS MEANS

This represents a significant reduction in reimbursement for care delivered to patients under the same demands for clinical quality since the NSA's implementation. This resource reduction is occurring in a setting of substantial clinical workforce shortages and unprecedented workplace strain. While some reports suggest that overall reimbursement for OON care has increased during *No Surprises Act* implementation, EDPMA survey data show a clear reduction in overall reimbursement for OON emergency care. Implications that health insurance premiums should be increased because providers are seeking fair reimbursements via Federal IDR in limited circumstances are unsubstantiated.

Universe of Out of Network Claims Reported

Despite this 39% reduction in reimbursement, only 33% of eligible claims were submitted to the IDR process. The other **67% of those claims never resulted in an IDR submission** according to respondents for a variety of reasons.



67% of eligible claims never resulted in an IDR submission

WHAT THIS MEANS

Data show that the overwhelming majority of out-of-network claims for emergency services never enter the Federal IDR process, demonstrating that providers rely on Federal IDR to determine out-of-network reimbursement a minority of the time.

Independent Dispute Resolution Outcomes

According to respondents, providers prevailed in 73% of Federal IDR disputes as determined by independent experts.

These survey results closely align with the most recent data cited by the Departments for January 1 – June 30, 2023, which found that providers prevailed in 77% of resolved disputes.[1]

WHAT THIS MEANS

The Independent Dispute Resolution experts substantially agree that the provider's offer for OON reimbursement is more reasonable than the health plan's offer. The rate at which certified IDR experts select the provider's offer is likely due to a combination of factors:

- providers tend to advance only the most egregious health plan underpayments;
- the injection of unexplainably low QPAs into the process;
- reasonableness of the offers submitted by providers.

Supplemental Background on Federal Independent Dispute Resolution Public Use Files (January 1, 2023 - June 30, 2023), www.cms.gov/files/document/federal-idr-supplemental-background-2023-q1-2023-q2.pdf (accessed April 16, 2024).

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Independent Dispute Resolution Back Log

Only 7.6%

of filed disputes have successfully gone through the IDR process to closure.

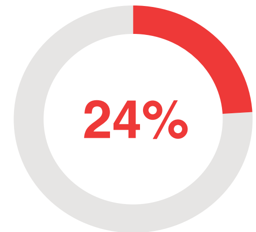
211 Days

The average age of disputes in the Independent Dispute Resolution process is **211 days** (7 months).

WHAT THIS MEANS

Coupled with the consequential reductions in payment, this significant backlog and delays in IDR results hamper both resources and cash flow for emergency medicine practices. This contributes to difficulties in advising appropriate in-network rates and impacts the resources available to ensure timely access to emergency care.

Payment To Providers After IDR Determination



Survey respondents indicate that commercial health plans frequently fail to pay providers when a payment determination is made (by a certified IDR entity) that results in the health plan owing dollars to the provider. Survey data shows that **24% of disputes are still not paid or were paid an incorrect amount** within 30 calendar days of the IDR entity payment determination, as required by statute and regulation.

WHAT THIS MEANS

We believe all parties should comply with the NSA statute and its regulations. Failure to comply with payment requirements significantly impedes physician practice cash flow and impacts timely access to patient care. The *No Surprises Act* tenet of ensuring patient access to care while taking patients out of the middle of health plan/provider billing disputes hinges on enforcement. When health plans continue to ignore the NSA statute and regulations and refuse to comply with certified IDR entities payment determinations, the NSA and its protections are undermined.

In-Network Contracts Terminated Or Reduced

The majority of respondents reported that they experienced termination of commercial health plan agreements or had renewed commercial health plan contracts with rate cuts in 2023.

WHAT THIS MEANS

Because health plans have used the QPA calculation methodology to generate and pay non-market-based rates, health plans have forced physicians out of network, or demanded unilateral and substantial rate reductions to stay in network, resulting in health plan-driven instability in provider practices across many networks.

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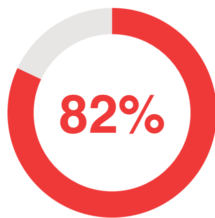
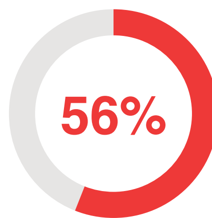
Health Plan Non-Compliance With NSA Requirements



82% of OON claims did not attest that the Qualifying Payment Amount (QPA) was calculated as required by statute and regulation.

56% of OON claims did not include the statutorily-required inflationary adjustment to the QPA as required by the IRS via statute and regulation.



WHAT THIS MEANS

Failure to add the required inflationary increase means:

- In addition to an often faulty or unverifiable QPA, health plans are under-reimbursing providers compared to the requirements in the *No Surprises Act*.
- For disputes that advance to Federal IDR, IDREs refer to an understated QPA that is out of compliance with statute and regulation, to the detriment of providers.

50%

of respondents report that health plans **increased the patient's cost sharing amount** after an IDR entity determination.

WHAT THIS MEANS

Protecting patients from surprise medical bills is a foundational tenet of the *No Surprises Act*, and it is being violated by health plans. Extrapolating the survey's rate at which health plans are altering patient cost-sharing factor after the initial payment, thousands of such claims may have been illegally revised, inappropriately attributing increases in cost-sharing to patients and inappropriately reducing amounts that health plans owe providers.

Complaint Response By Government Agencies

19,047 complaints

▶ **Only 1.3% complaints resolved**

EDPMA survey respondents alone submitted **19,047 complaints** to the Department of Health and Human Services, the Department of Labor, and the Treasury Department in 2023 and report that **only 1.3% of these complaints have been resolved.**

WHAT THIS MEANS

While the implementation of significant new legislation takes time and will require process improvements, the ability to make improvements hinges on stakeholder input and real-world user experiences. Providers share key insights with the Departments into the issues related to implementation and health plan compliance. However, failure to respond to those issues threatens the effectiveness of the rules and the ability to achieve the goals of the legislation.