EDPMA 25 YEARS

Data Analysis

Qualifying Payment Amounts and Health Plan Compliance Under the No Surprises Act

The Emergency Department Practice Management Association (EDPMA) is a trade association focused on the sustainable delivery of high-quality, cost-effective patient care in emergency departments. Our members deliver or directly support health care for approximately half of the 146 million patients that annually visit U.S. emergency departments.

The Study

EDPMA surveyed its membership to report on issues related to the implementation of the No Surprises Act (NSA) since January 1, 2022. Specifically, EDPMA analyzed the out-of-network allowed amounts commercial health plans reimbursed for services and whether the Qualified Payment Amount (QPA) was disclosed to the provider as required by law. EDPMA also reviewed members' experiences of the Independent Dispute Resolution (IDR) process. We then conducted a subsequent survey to compare out-of-network allowable amounts in 2021 prior to the NSA to 2022 allowable amounts, after the NSA was implemented. The surveys found nearly universal payer non-compliance with even basic statutory requirements, payer-calculated QPAs that were inconsistent with actual in-network payments, and a clear regulatory failure to effectively enforce the law. This is a high-level summary of initial findings; additional details are forthcoming.

The Numbers

14,500 claims from 35 States
Date range: January – May 2022
59 local, regional, and national practices
Antitrust Safe Harbor status maintained[1]

The Findings

Health Plans routinely fail to comply with the NSA's statutory and regulatory QPA disclosure requirements.

91% of claims surveyed did NOT include an identified QPA as specifically required by law. There is no known enforcement related to this pervasive health plan non-compliance.

Post-NSA Out-of-Network Payments decreased 92% of the time, compared to Pre-NSA. The average decrease is 32% per ER visit.

EDPMA studied 2021 out-of-network data in nine states. Allowed amounts for Level 4 and Level 5 claims (which make up most ED visits) decreased 92% of the time. Of these claims, there was a 32% decrease in reimbursement levels for clinically identical services pre-NSA. This abrupt and dramatic reduction significantly risks how EDs deliver emergency care. Emergency Departments are relied upon to deliver half of the care for the uninsured and 30% of the care to Medicaid patients.

[1] Redacted data must be at least 3 months old; at least 5 data contributors per published dataset; no group contributing more than 25% of a data set; raw data only reviewed by a third-party independent consultant.

The Independent Dispute Resolution volumes are driven by artificially low QPAs, payer intransigence, failure of Open Negotiation, health plan termination of in-network agreements, and CMS' refusal to implement common-sense recommendations.

Certified IDR Entities are attempting to process disputes at a much higher volume than estimated. The balanced law passed by Congress was significantly skewed by the NSA regulations, resulting in dramatically lower payments and more out-of-network claims. The QPA survey results suggest artificially low QPA calculations that are not reflective of a market-based payment rate. This could be due to the regulations establishing the QPA calculation methodology or due to health plans improperly applying the QPA methodology. These unsustainably low initial payments have created significant and unanticipated volumes of IDR initiations. The Tri-Departments reported in the first five months that providers initiated five times more disputes than the government anticipated for a full year.[2][3] Significant delays in resolutions (up to 6 months) drive substantial negative cash flow for emergency physician groups and result in additional threats to patient access to care.

When reported, the QPA consistently equals the allowed amount for provider payments.

While the statute avoided setting an initial payment benchmark and instituted no requirement that the paid amount equal the QPA, results find that health plans are commonly paying at a rate that equals the QPA at least 93% of the time. This finding highlights that health plans are misapplying the presumed credibility of QPAs as a payment standard, despite evidence that they do not accurately reflect in-network rates when the NSA specifically avoided the inclusion of a benchmark payment standard.[4]

EMTALA is now minimally funded, jeopardizing the Emergency Department Safety Net.

Poorly written rules and inattentive regulators have emboldened commercial payers to slash both in-and-out-of-network reimbursement for emergency care. These decisions have begun to erode funding for patients' guaranteed access to emergency care under EMTALA. This unsustainable model now heavily relies on hospitals that are also in distress. Without intervention, HHS' implementation of the No Surprises Act threatens to cripple our healthcare safety net.

Emergency Department staffing is in jeopardy.

Since the No Surprises Act, emergency medical groups are expected to lose almost $1 billion annually. If the current NSA implementation goes unchecked, this model will cripple emergency departments, risking access to emergency care. Emergency departments serving rural and underrepresented communities are especially at risk.

The Solutions

To ensure a sustainable healthcare safety net, emergency physicians must be fairly compensated in a timely manner for services already delivered, especially if those services are required under the federal EMTALA law, which provides both a guaranteed network for health plans and a safety net for patients.

Congressional Involvement

Congress should ensure that the bipartisan No Surprises Act not only keeps patients out of the middle of payment disputes but is implemented as intended. This includes aligned implementation policies for health plans and providers, efficient and cost-effective dispute resolution, appropriate transparency, and effective enforcement processes. Congress' continued assistance and involvement is key to achieving the agreed-upon goals of this landmark legislation.

[2] https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/federal-independent-dispute-resolution-process-status-update.pdf
[3] https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf
[4] The allowed amounts for emergency medicine services range from a weighted average of 126% to 145% of 2022 Medicare rates. These levels represent cuts of at LEAST 25% - 65% from pre-NSA average out-of-network reimbursement levels for emergency medicine.

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Rapid and Effective Enforcement

The Tri-Departments must uphold the NSA statute and ensure that ALL eligible claims clearly disclose the required QPA. Non-compliance with this and other provisions must be quickly and effectively enforced. EDPMA calls on the Tri-Departments to immediately begin robust audits of the QPAs and correct health plan non-compliance issues, including failing to report the QPA, and provide stakeholders with transparency into enforcement processes and results in real-time.

Accurate QPAs

The Tri-Departments must ensure QPAs are calculated as intended by law to reflect the patient's out-of-network financial responsibility and not the provider's out-of-network reimbursement. Audits should examine not just the payer's strict adherence to the methodology developed by the Departments, but whether the methodology itself results in QPAs that deviate materially from the true median of in-network reimbursement. Audits should be made public as they are completed; to arbitrarily withhold audit results until an "end of year report" during the first crucial years of implementation would be a significant dereliction of regulatory responsibility.

Require RARC Codes

Without RARC information from health plans, emergency medicine physicians cannot effectively navigate resolution processes when they receive inadequate or inappropriate payments for clinical services. EDPMA calls on the Tri-Departments to immediately mandate, not just "strongly recommend," that the most specific available RARC codes be communicated by the health plans at the time of initial payment in the mandated ANSI 835 remittance advice sent to physicians and hospitals.

Clarify RARC Codes

NSA-specific RARC codes are rarely communicated. When a RARC specific to the NSA is communicated, N830 is used in 93% of claims. This code informs the provider that the claim was processed EITHER under the federal OR a state balance billing law. In states with a Specified State Law, this code does NOT identify ERISA/non-ERISA claims or other characteristics that could place the claim under federal or state jurisdiction. To reduce the volume of unnecessary IDR claims, the Tri-Departments must require health plans to use the most specific NSA RARC from the list CMS developed earlier this year and a clear ERISA identifier in the ANSI 835. By mandating the use of an ERISA identifier and the most specific available RARC codes, the Tri-Departments will expedite the IDR process and reduce the unintentional submission of ineligible claims.

EMTALA Must Now Be Funded

Since 1987, the federal law EMTALA has required hospitals to provide clinical care to all patients without regard for their ability to pay. This requirement is significant and applies to almost all emergency care provided in US hospitals. However beneficial, EMTALA was never funded. Now, with commercial reimbursement plummeting due to the manner of implementation of the NSA, the previous equilibrium is significantly disrupted. EMTALA-required care, stand-by costs, uninsured care, and underinsured care have no offset in a system that requires care for all patients without a corresponding requirement of fair reimbursement. We must now step up to ensure that the healthcare safety net is sustainable and that patients can reliably receive emergency medical care. Without solutions, the patients we serve will be at a very real risk.

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