EDPMA

Data Analysis

Independent Dispute Resolution in the No Surprises Act - Deficiencies and Compliance Failures

July 2023

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 see or support 60% of all annual emergency departments (EDs).

The Study

EDPMA surveyed its membership to report on issues related to the implementation of the No Surprises Act (NSA) and its Independent Dispute Resolution (IDR) process since the statute was made effective on January 1, 2022. This data documents our members' experiences with the IDR process and represents a high-level summary of initial findings; additional details are forthcoming.

The Numbers

EDPMA's respondents were polled in three surveys with the results consolidated and compiled into a single report. The largest responses, representing the majority of questions, sampled over half of EDPMA's annual emergency department patients.

- This accounts for at least one-fourth of all ED visits in the United States
- 355,800+ IDR claims were filed by respondents
- Date range: January 2022 – December 2022
- Antitrust Safe Harbor status was maintained [1]

The Findings

91% Of Filed IDR Claims Remain Open and Unadjudicated

Respondents reported almost 200,000 outstanding claims, out of 220,000 claims filed with IDR in the first survey. In an updated survey covering 355,800 claims filed with IDR, outstanding claims were not re-surveyed in that iteration. Assuming the outstanding claims were still 91% of the total filed claims, the adjusted outstanding total claims would be approximately 323,800. Payers ignoring claims in the open negotiation period contribute to the significant volume of IDR claims. [2]

95.6% of Outstanding IDR Claims Are 5+ Months Old and Involve 127 Health Plans

Our study reveals outstanding claims by date range:

< 30 days:	0.1%	91-120 days:	0.6%
30-60 days:	0.5%	121-150 days:	44.2%
61-90 days:	3.2%	>151 days:	51.4%

If the current NSA implementation goes unchecked, this phenomenon will cripple those who staff emergency departments, ultimately risking patients' access to quality emergency care. These emergency departments often serve rural and underrepresented communities, who are the first to be affected.

[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.
[2] https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf

The Findings (cont.)

Payers Are Failing to Meaningfully Participate in the 30-Day Open Negotiation Period and IDR Process As Provided for in the Statute

- Respondents averaged NO replies from health plans 46% of the time in the periods surveyed during the 30-day Open Negotiation period.
- Respondents further reported that 52% of payers did not acknowledge an IDR claim had been filed and
- 75% of payers who actually responded in the IDR process made NO actionable offers.

60% Of Payers Are Not Updating the QPA Amounts with the Statutorily Required Inflationary Update

The QPA is one factor considered by IDREs to decide an IDR claim. First, while QPAs are anchored to 2019 contracted rates, according to statute and regulation, they must be updated annually for inflation. As such,

- The Internal Revenue Service instructed payers to use an update factor of 6.485% for the QPA calculations from 1/31/2019 contracts for 2022 (page 5, https://www.irs.gov/pub/irs-drop/rp-22-11.pdf).
- Then the IRS then instructed payers to update 2022 QPA calculations for 2023 by an update factor of 7.685% (page 8, https://www.irs.gov/pub/irs-drop/n-23-04.pdf).

This direction from the IRS results in 2019 QPA calculations that should have been increased by approximately 14.669% for services furnished in 2023. The cumulative increase of 14.669% from 2019 to 2023 takes into account the compounding effect of applying the 2023 adjustment (7.685%) to the 2022 rate (already adjusted by 6.485% over 2019). Yet, 60% of respondents reported that they cannot verify an increase in their QPAs as required by the statute from 2022 to 2023, correlating with the 7.685% inflationary rate. This widespread failure of health plans to follow the law and properly adjust their 2019 QPAs is one important factor driving the demand to file IDR claims. Since the QPAs-- on which most plans base their initial payments--are artificially low without the inflation adjustment, the only recourse for providers is to file IDR claims.

Rapid and Effective Enforcement Is Lacking

Physician groups are filing complaints with CMS and CCIIO and issuing demand letters to health plans. Despite these efforts, emergency physicians continue to experience a pro-payer process. Respondents reported that CMS has only responded to approximately 14% of their complaints.

IDREs Do Not Provide Required Criteria for Their Decision Making

According to the survey results, IDREs select the offer of the health plan only 30% of the time. In these instances, we have found that 70% of the time, the IDREs do not provide the provider with the required criteria that shaped the IDREs' decision.

87% of Payers Did Not Pay in Accordance with the IDR Entity Decision

Payers' blatant disregard of the No Surprises Act's intent and CMS-issued guidance undermines the law and guts fair emergency physician reimbursement that underpins emergency care in America. Of the survey respondents, 60% quantified the percentage of payments won in IDR but NOT paid within the prescribed 30 calendar days. Concerning this sizeable 60% not paid within 30 days, 1/3 of these claims as of the survey date were reported to still be 100% non-compliant by health plans (either no payment or underpayments); another 1/3 paid beyond 30 days reported noncompliance from 89% to 98% of the time (either no payment or underpayments); and the final 1/3 paid beyond 30 days reported noncompliance averaging 37% of the time (either no payment or underpayments).

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.

Implement the Law as Designed

The Administration should not alter the law Congress passed, should ensure that all parties have fair and appropriate access to the provisions contained in the law, and should enforce compliance with the law by all parties.

Rapid and Effective Enforcement

The Tri-Departments must uphold the NSA statute and ensure that when required, ALL parties fully participate in the IDR process with a common spirit of fair and timely resolution of disputed claims. Payers who refuse to comply with the IDR process or fail to pay as directed by the IDR entity should be subject to penalties and fees.

Congressional Involvement

Where necessary, 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, while also preventing the NSA from becoming a landmark failure by undermining the viability of emergency physician groups–who provide the core of our national emergency safety net.

EMTALA Must Now Be Funded

Since 1987, the federal law EMTALA mandates that emergency physicians treat all patients regardless of 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. And, the No Surprises Act is causing commercial reimbursement to decrease, upsetting the current equilibrium. Now, EMTALA-required care, stand-by costs, uninsured care, and underinsured care have no offset in a system that requires care for all patients. We must find a way to ensure that the U.S. emergency care system is sustainable and that emergency medicine physicians can deliver much-needed care. Our nation's healthcare safety net hangs in the balance and needs solutions.

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