September 14, 2023

The Honorable Xavier Becerra
Secretary, Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Julie A. Su
Acting Secretary
Department of Labor
200 Constitution Ave NW
Washington, DC 20210

The Honorable Janet Yellen
Secretary
Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

Dear Secretaries Becerra, Su, and Yellen:

The Emergency Department Practice Management Association (EDPMA) writes to you today because we believe that with improved regulations and enforcement, the *No Surprises Act* (NSA) will meet Congress's goals of protecting patients, sustaining provider networks, and ensuring access to emergency care. A functional law will significantly benefit patients, employers, and clinicians, and reduce the need to access Independent Dispute Resolution (IDR). We further believe that the Departments of Health and Human Services, Labor, and Treasury ("the Departments") have the tools and ability to make the NSA fair and balanced and to rebuild provider networks, which will benefit patients, clinicians, and health plans alike, all per the intent of Congress in passing the *No Surprises Act* in 2020.

EDPMA is the nation's only professional trade association focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups of all sizes, billing, coding, and other professional support organizations that assist healthcare clinicians in our nation's emergency departments. Together, EDPMA members see or support 60% of all annual emergency department visits in the country.

EDPMA and its members are active stakeholders and firm supporters of the *No Surprises Act*. However, we believe that the Departments have, in many instances, written implementing regulations inconsistent with the law as passed by Congress. EDPMA has been actively engaged with the Departments and have communicated our concerns in over a dozen letters.

It is important to further note that emergency medicine practices strive to be in-network with health plans and make meaningful attempts to contract with health plans. Often, however, we find we do not have a willing payer partner in these negotiations. Many payers now find it 'easier' to merely terminate long-standing in-network agreements with emergency physicians and instead, default to the NSA's currently flawed implementation. As a result, given the dramatically lower payments for out-of-network services health plans are imposing, by using the currently skewed Qualifying Payment Amount (QPA), together with the inability to secure or maintain in-network contracts, emergency physicians' only option is to use the Open Negotiation and Independent Dispute Resolutions (IDR) process to attempt to achieve fair reimbursement. This too provides little recourse because the IDR processes are broken and often inaccessible, and health plans have little incentive to utilize IDR payment determinations as meaningful reference points for in-network agreements.

Commercial health plans are using the *No Surprises Act's* implementing regulations to disrupt payment to clinicians by paying inadequately or not paying at all. Further, the current incentives have resulted in a universe in which plans simply fail to engage in the IDR process. EDPMA members report that 52% of the time, payers do not acknowledge an IDR dispute has been filed. And of the payers who actually respond, 75% do not make an actionable offer.

Consequently, physician groups' cash-flow is interrupted and clinical resources are reduced, affecting timely access and quality care for patients. The stability of clinical practices is at significant risk.

Given the significant issues around the implementation of and processes embedded in the *No Surprises Act*, EDPMA offers the following additional recommendations and solutions to continue our efforts as productive stakeholders.

EDPMA addresses five primary areas of concern below:

1. Overview and Perspective: Unique aspects of emergency care
2. Qualifying Payment Amount ("QPA"):
- QPA Methodology
- QPA transparent disclosure
- QPA Audits

3. Eligibility: Recommendations for eligibility allowing the efficient and effective use of the Open Negotiation period and the Independent Dispute Resolution (IDR) process.
- Use of RARCs
- Clarity on responsible financial party

4. Independent Dispute Resolution: Recommendations for clarity throughout the Independent Dispute Resolution process and suggested solutions to reduce dependency on the process and ease the burden on certified IDR entities (IDREs).
- Open Negotiation Recommendations

5. Enforcement: Recommendations on current enforcement opportunities and suggestions to solve IDR non-compliance.

1. Overview and Perspective: Unique aspects of emergency care

Before providing our recommendations, EDPMA offers an overarching perspective on the unique aspects of emergency care that frame our comments and suggested solutions.

We understand that the process of rule-writing rightfully seeks uniformity and efficiency for all patient care settings and specialties. We support uniform approaches and broad provisions wherever achievable.

However, fundamental realities and ubiquitous differences in emergency care require a more focused approach. In the United States, all patients are guaranteed access to emergency medical care in a perceived emergency. Longstanding federal law, especially the Emergency Medical Treatment and Labor Act (EMTALA)[i] and the Prudent Layperson standard,[ii] guarantee access to emergency care. As emergency physicians, we strongly support both of these federal laws and welcome the additional patient protections offered in the *No Surprises Act,* provided that the EMTALA and Prudent Layperson Standard patient protections are accommodated in the implementation of the *No Surprises Act.*

Emergency physicians are subject to EMTALA, which requires that we provide patients with emergency medical care regardless of their insurance status, immigration status or ability to pay.[iii] EDPMA strongly supports the patient protections embedded within the EMTALA requirements. This includes that a hospital may not place any signs in the emergency department about the payment of fees, co-pays, and deductibles.

Additionally, hospitals and physicians may "not delay examination and/or treatment in order to inquire about the individual's insurance or payment status." In effect, EMTALA provides for a universal network of emergency care, irrespective of the existence of an in-network agreement between emergency care clinicians and health plans. However, this federal requirement provides no funding, no standard of payment, and no specific ability to collect amounts owed by patients or health plans after health care has been provided. These provisions are unique to emergency care in the entire United States, and are significantly different from other specialties, especially scheduled care settings.

These foundational principles of EMTALA's patient protections were enacted almost four decades ago. If emergency medicine physicians attempted to collect patient cost-sharing payments prior to their assessment and stabilization, it could cause the patient's condition to deteriorate due to the delay in critical care, and it would that be a significant EMTALA violation.

Due to the unscheduled nature of emergency care and EMTALA's unique requirements, providing emergency care includes logistics and requirements that are substantially different than other health care settings. Emergency

physicians cannot seek pre-authorization, verify insurance, or collect certain billing information prior to delivering emergency care. Additionally, emergency physicians are not able to collect patient cost sharing amounts at the time of service, especially for out-of-network claims.

The Prudent Layperson standard was first made part of federal law in the Balanced Budget Act of 1997 and subsequently adopted in both the ACA and other statutes/regulations. Since then, the federal Prudent Layperson Standard also protects both clinicians and patients from having to obtain prior authorization for patients who present to an emergency department.

EMTALA and Prudent Layperson Standards not only protect patients in need of timely care and ensure communities have 24/7 to access to emergency care (including during disasters and mass casualty events) but also create high standards and obligations for emergency physicians that must be acknowledged by and integrated throughout the *No Surprises Act.* To the extent that the NSA's provisions do not accommodate the requirements of EMTALA and the Prudent Layperson standard, the resulting dramatic reductions in payments for emergency care will cause the entire economic ecosystem of emergency care to fail. This would be a severely detrimental, unintended consequence of the No Surprises Act – one that affects our nation's unique healthcare safety net.

EDPMA believes there are efficient solutions that accommodate these realities, and we offer these below.

EMERGENCY MEDICINE: UNIQUE FROM A CLINICAL AND REIMBURSEMENT PERSPECTIVE

As stated, emergency care involves the unscheduled acute diagnosis, treatment, and stabilization of diverse and undifferentiated clinical conditions.

For example, two of the most common patient presentations to the emergency department are "chest pain" and "abdominal pain." These initial presenting complaints have a broad range of final diagnoses and may require a variety of patient-specific lab tests, radiology exams, and other interventions to ensure that the emergency medical condition has been identified and stabilized as required by EMTALA.

Evaluating, stabilizing, and treating patients based on their presenting systems is very different from assessing and treating a patient in a scheduled, office-based setting with a previously determined diagnosis. In fact, if a patient in an office-based setting requires urgent evaluation and/or stabilizing care, they are usually immediately referred to the emergency department.

- A Rand study reports that emergency departments are increasingly used by primary care clinicians to perform accelerated diagnostic workups of patients with potentially serious problems.[iv] Conversely, expedited evaluation often avoids a hospitalization by safely determining that a hospitalization is not necessary.
- The Rand report further referred to a Berenson & Rich study, "The time pressure on primary care physicians has grown so great, many regard any unscheduled visit, even one involving a relatively minor problem, as a disruption to their workday."[v]
- The American Academy of Family Physicians reports that many primary care physicians' offices are not prepared for an emergency presenting in their office.[vi] And it is common that most office-based physician offices and health insurance companies' direct callers to hang up and call 911 if they are experiencing a medical emergency.
- As the Rand report summarizes: "Most patients who visit an ED for a non-emergent health problem do so because they were sent by a health care clinician, believed they had a serious condition, or perceived that they lacked a viable alternative."[vii] The people directed by their office-based physician then present in the emergency department as undifferentiated patients to the ED. Because all patients require and deserve a prompt medical screening exam and stabilizing treatment in the emergency department in accordance with the Prudent Layperson standard and EMTALA, the complicated and unpredictable nature of emergency care makes it impossible to estimate ahead of time what services are going to be delivered during an individual patient encounter.

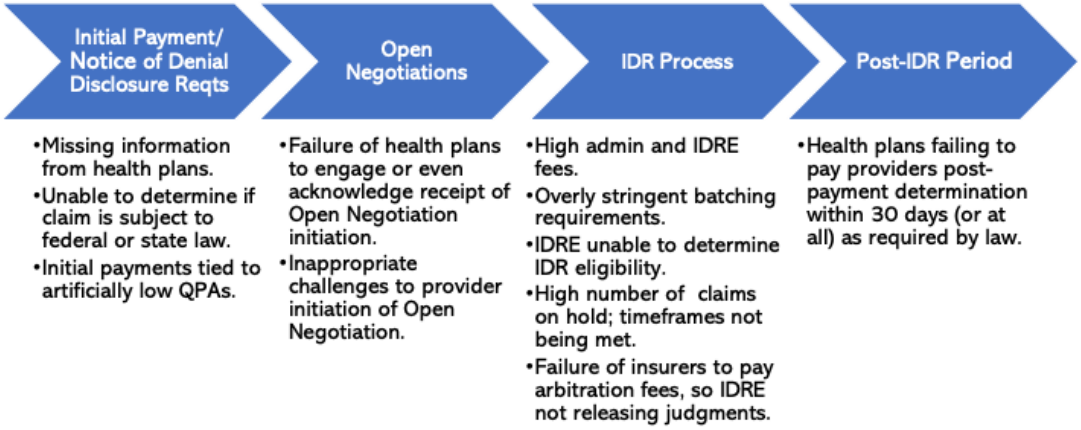
The EMTALA patient protection requirements not only influence how emergency medicine clinicians interact with patients — but they also impact how and when health plans determine the appropriate cost-sharing amount for the timely services already rendered.

Patients often do not have insurance information with them nor the ability to pay their cost-sharing portion at the time of the emergency department visit. As directed by the EMTALA statute, a medical screening examination and stabilizing care must be completed *before* seeking insurance information and/or payment.

In fact, physician groups often do not know the patient's definitive insurance information for several days or weeks after their emergency care encounter. And, unlike scheduled care when the cost-sharing amount is known and collected up-front, physician groups do not bill, nor do they attempt to collect cost-sharing payments from patients for emergency care until *after* the health plan determines what the total allowable amount for the services will be — which is long after the patient has been discharged from our care and the emergency department. So, it is both legally and logistically impossible for emergency physicians to collect cost share from patients before or immediately after the service is provided.

These realities have created confusion about when the *No Surprises Act* applies and what the appropriate venues for resolution are. EDPMA believes that the Departments should take every possible action to address these system vulnerabilities that might result in confusion about whether state or federal rules apply to out-of-network services. The Department can achieve significant improvement in the related processes and ensure that only eligible disputes end up in Federal IDR by (1) requiring health plans to include the plan type on patient insurance identification cards; and (2) by mandating the use of Remittance Advice Remark Codes (RARCs) (which we discuss in further detail below).

Refer to the visual representation of emergency medicine billing, the Independent Dispute Resolution process, and challenges with the *No Surprises Act* below:



2. QUALIFIED PAYMENT AMOUNT (QPA)

Since March 2021, EDPMA and others, have sent 15 letters[viii] to the Departments, the Center for Medicare & Medicaid Services (CMS), and the White House Office of Management and Budget (OMB) offering solutions-based recommendations to fix the implementation of the *No Surprises Act.*

EDPMA and its members, who represent 60% of annual US emergency department visits, view fixing the QPA as the most important concept in future NSA rulemaking. As we have written several times and as acknowledged in federal court, the regulations related to calculation of the QPA are flawed. This is further compounded by the fact that many health plans fail to properly adjust their 2019 QPAs for inflation as required by law and regulation. These two factors are a large driving force in the demand to file IDR disputes. While not required by law, most plans base their initial payments on the QPA – when the QPA is artificially low, often without the legally required inflation adjustment, the only recourse for providers is to file Open Negotiation requests and subsequently file claims for Independent Dispute Resolution when the dispute has not been resolved in Open Negotiation. This is a frequent event because of health plan behavior: EDPMA members report that 46% of the time, health plans did not reply during the 30-day Open Negotiation period.[ix]

The Departments reported nearly 14 times as many federal IDR disputes as originally anticipated.[x] Although we are unconvinced that the original estimates had a solid foundation, the current number of IDR disputes is almost entirely

in direct response to the unreasonably low initial payment based on an unreasonably low QPA or a payment made without identifying the required QPA.

For example, in 2022, the average initial payment and/or QPA for a local Third-Party Administrator (TPA) in downstate New York was less than 90% of Medicare rates for that locality. Such payments are almost 3 times less than payments received in years prior to NSA implementation. Additionally, EDPMA members report that 60% of payers are not updating the QPA amounts with the statutorily required inflationary update.[xi]

When a clinician is paid an unreasonably low initial payment or does not receive the required information on the QPA to understand the basis for the payment, their only recourse for fair payment is to initiate Open Negotiation. Most Open Negotiation requests are simply ignored by the health plan. This strains the entire process and is the primary reason the Departments report that there were nearly 14 times as many federal IDR disputes as anticipated.[xii]

By fixing the initial payment and QPA, our health system will benefit from a process where both parties participate in good faith, clinicians are fairly reimbursed in a timely manner for already-delivered emergency care, especially those services delivered under the federal EMTALA law, and the *No Surprises Act* is implemented as enacted.

EDPMA suggests the following solutions:

MODIFY THE METHODOLOGY TO ENSURE THE QPA REFLECTS MARKET RATES
EDPMA and the American College of Emergency Physicians (ACEP) have requested numerous modifications to the QPA methodology in previous comments.

> **EDPMA requests that the Departments base the QPA rate on the total number of actual payments issued to individually contracted physicians. By basing the QPA on claims rather than contracts, the QPA would more accurately reflect the actual negotiated rates between payers and clinicians.**

TRANSPARENT DISCLOSURE of the QPA
Only the health insurance plan can calculate the QPA. Often, physician groups do not receive information about the QPA, how it was calculated, the plan type, nor if it was adjusted for inflation. If this information was provided at the time of the claim adjudication, many IDR claims would be avoided.

> **EDPMA recommends that the Departments enforce the requirements for plans to disclose the QPA concurrently with the initial payment in compliance with current regulation and to do so in an easily identifiable, user-friendly format. Further, EDPMA recommends the Departments require that plans disclose the market the QPA is based upon (i.e., individual, small, large group market, a self-insured market) or if it is based on an all payers database (APD) or an all payers market analysis (APMA), if so, which APD/APMA and disclose what inflation adjustments (by year) have been made to comply with 45 CFR 149.140(c)8.**

AUDIT QPA CALCUATIONS
We reiterate and request the Departments audit QPA calculations in accordance with the Act. Additionally, we request the Departments publicize which health plans will be audited, and whether or not the health plan's QPA(s) were in compliance with the Act.

3. ELIGIBILITY
EDPMA offers these eligibility recommendations to allow the efficient and effective use of the Open Negotiation period and the Independent Dispute Resolution process.

As you know, the *No Surprises Act* created many new administrative processes and EDPMA requests that the Departments consider ways to limit the administrative burden on all parties. Since January 2022, clinicians have often found it challenging to appropriately identify whether state or federal rules and processes apply to an out-of-network claim. In fact, the Departments issued a status update on April 27, 2023, in which they acknowledge the "primary cause of delays in the processing of disputes is the complexity of determining whether disputes are eligible for the federal IDR process."[xiii]

USE OF REMITTANCE ADVICE REMARK CODES (RARCs)

A report issued by the Departments states that it "is difficult to determine because the health plan type is unknown upon dispute initiation in approximately one third of disputes in Texas and Florida and over half of disputes in Georgia," all of which have specified State Laws. The departments had to hire consultants to help determine eligibility. The high volume of ineligible claims directly results from health plans not disclosing the plan type covering the patient at the time of the initial claim remittance."[xiv]

When health plans and issuers adjudicate claims and communicate information to the health care clinician, they do so in a standardized format called an ANSI 835 (835) remittance. The 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.

Appropriate RARCs already exist and are common for both health plans and clinicians, so mandating their use will not require changes to the templates that health plans and issuers typically use to relay information about a claim to a clinician. Said another way, there are enough fields on the standard 835 remittance to accommodate the *No Surprises Act*-related RARCs.

EDPMA recommends that the Departments request a modification to the standard 835 remittance form so that all the information, including the QPA, is disclosed uniformly. Again, there are open fields and appropriate RARCs are in place that will resolve many issues with *No Surprises Act* implementation, but the open fields will need to be designated to be used for the required NSA information.

Requiring plans to use RARCs when providing the initial payment or denial notice will clarify state or federal eligibility for out-of-network dispute resolution and reduce confusion and unnecessary administrative transactions and delays. It will reduce "ineligible" claims being submitted for IDR, which reduces administrative burdens and backlogs for all parties.

Specifically, group health plans or health insurance issuers should be *required* to use exactly one of two mutually exclusive RARC codes with the initial payment or notice of denial to clearly identify whether state or federal rules apply:

> **N871 Alert:** This initial payment was calculated based on a state specified law, in accordance with the *No Surprises Act.*
>
> ***OR***
>
> **N859 Alert:** The Federal No Surprise Billing Act was applied to the processing of this claim. Payment amounts are eligible for dispute pursuant to any Federal documented appeal/ grievance/ dispute resolution process(es).
>
> Use of both N871 and N859 together on a claim renders their use moot and should be prohibited.

EDPMA recommends these processes and remedies for failure to use appropriate RARCs on the initial payment or notice of denial.

- Should the clinician not receive a RARC code delineating whether state or federal rules reply to a claim for an item or service furnished out-of-network with the initial payment or denial and the provider has reason to believe the federal rules apply, the clinician may make a notation on the Open Negotiation notice indicating each item or service that did not receive a RARC. The Departments should also make and enforce a provision that a clinician may add a statement to the Open Negotiation notice requesting the health plan to provide the RARC for each claim within ten (10) business days of receipt of the Open Negotiation notice.

- If a "State Specified Law" applies to a claim and the health plan did not return the appropriate RARC at the time of the initial payment or notice of denial, the clinician has the option of following the federal or state process. In either case, fees are paid solely by the non-compliant party.

- If the claim is appropriately subject to the federal IDR process and the payor returned a RARC indicating the claim was subject to a "Specified State Law," then the clinician has the option of following the federal IDR process OR following the "State Specified Law," procedure if the State allows the claim to enter the state's process.

  In either case, any federal nonrefundable filing fees and IDRE fees are paid solely by the health plan. Additionally, any deadlines for federal IDRE open negotiation letter submission are extended to 30 days after the payor notifies the clinician with the correct RARC code that the claim is subject to federal IDRE.

  In summary, If the health plan did not provide the correct appropriate RARC code on the first remittance, the health plan should be estopped from benefiting by forcing the clinician to the federal IDRE or "Specified State Law."

CLARITY ON RESPONSIBLE FINANCIAL PARTY

Current NSA Rules state that items and services "may be considered jointly as part of one payment determination by a certified IDR entity only if the batched items and services meet" certain requirements, including "by the same plan or issuer". The Act does not define "group health plan" or "health insurance issuer", however, those terms are defined in pre-existing portions of ERISA and the Public Health Service Act. It follows that the existing definitions of "group health plan" and "health insurance issuer" confirm that parties must batch by the *same employer-funded plan* and not the third-party administrator.

Accordingly, EDPMA recommends that the employer-funded plan is named with the initial payment or denial. Clinicians require clarity and specificity regarding employer-funded plans to ensure they can batch correctly and efficiently.

Specificity and clarity on the employer-funded plan may be conveyed as follows:

> The ANSI 835 remittance accompanying the initial payment or denial notice must include the employer-funded plan with whom the clinician may initiate the Open Negotiation and/or IDR process. The Departments should enforce meaningful penalties for non-compliance. The required information shall include the employer-funded plan and a US mailing address and/or functional e-mail address.

EDPMA recommends remedies for failure to correctly disclose the responsible party:

> Failure to include the correct information will result in an automatic adjudication in the amount initially requested by the clinician during Open Negotiation.
>
> All filing or administrative fees paid to an IDRE and/or the Departments shall be refunded to the compliant party and simultaneously paid by the non-compliant party. Additionally, the non-compliant party shall pay the compliant party a $50 penalty.

4. EDPMA RECOMMENDATIONS TO REDUCE DEPENDENCE ON THE INDEPENDENT DISPUTE RESOLUTION (IDR) PROCESS

Expanding the Scope of the Federal IDR portal

A robust and comprehensive federal IDR portal would formalize the Open Negotiations process and provide a more structured way for health insurers and clinicians to have certainty of when the 30-day Open Negotiations process begins, to share information, and use best efforts to resolve disputes before the IDR process (including assisting with eligibility determinations). 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.

An improved portal would increase efficiency for *all* parties by:

- ensuring each party is appropriately notified the IDR process has commenced.
- ensuring each party receives accurate and complete information regarding each claim;
- providing a clear and accurate timeline of all communications exchanged throughout the process;
- ensuring compliance with the law and determinations of IDREs.

EDPMA recommends the following functionalities for a comprehensive IDR portal:

Administrative Log-Ins. All parties should be given administrative logins for the portal. Each administrative username will let the party review all pending or closed actions and/or disputes. Also, each party with a username can select a primary e-mail address that will be automatically notified of communications or documents uploaded to the portal.

Proper Forum. If either party believes in good faith the dispute should be properly adjudicated via the comprehensive portal, the portal will accept the claim. This serves to memorialize the dates of filing and preserve the rights of the initiating party to file in the appropriate forum.

Use of the portal begins with the Open Negotiation notice. Federal requirements already establish that a party that wishes to access the federal IDR process to determine the out-of-network rate for an item or service, such party must send the other party an initiation of Open Negotiation notice. All parties will be aided if the party initiating Open Negotiation is required to utilize the portal to submit the Open Negotiation party to the non-initiating party.

Submission of Offers and Payment of Certified IDRE fee.

- Parties shall submit their offers through the portal and attest to payment. This function is already implemented.
- Any follow-up request by an IDRE will be done only through the portal. And subsequent documentation requested will be uploaded to the portal.
- All documentation uploaded to the portal will be readily available upon request by the other party within 24 hours of IDRE determination.

Other processes of IDR that will take place solely in the portal.

- Any communication, inclusive of settlement offers and acceptance, occurring during Open Negotiation will take place in the portal.
- Initiation of the IDR process by submitting a Notice of IDR Initiation through the portal.
- Selection of the Certified IDRE will occur within the portal.
- Communication with IDREs.

Other recommended features of the portal that will contribute to efficiency and efficacy of IDR process.

- Assign an identification number to specific items or services under dispute to better track them through the process.
- Implement timestamps for each step of the process.
- Clearly include the contact information, including the email addresses, for all contacts involved in the dispute.

OPEN NEGOTIATION RECOMMENDATIONS

As per statutory requirements,[xv] a party must send an initiation of Open Negotiation notice to the other party that includes information sufficient to identify the items and services (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 clinician, 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.

EDPMA members report that 46% of the time, health plans did not reply during the 30-day Open Negotiation period.[xvi] Additionally, based on experience and data, the 30-business day Open Negotiation period, in most cases, has become a delay, rather than an opportunity, to resolve payment disputes**.** The lack of meaningful engagement by health plans in the critical Open Negotiation process forces clinicians to submit claims through the IDR process.

Accordingly, EDPMA recommends mandating participation by clinicians and health plans in Open Negotiation as follows:

- Health plans must respond to an Open Negotiation notice via the portal within 10 business days of receipt of the notice.
- Declining to negotiate the initial payment or notice of denial will accelerate the time frame by which the clinician may initiate IDR. Upon receipt of communication declining to negotiate, clinician may initiate IDR beginning on the 11th day of Open Negotiation.

- Failure to respond to an Open Negotiation Notice within 10-business days will result in a forfeiture of IDR eligibility for the plan and the clinician shall automatically be awarded (via the portal) the requested amount in the open negotiation request.

5. ENFORCEMENT

EDPMA is alarmed by the growing trend of health insurers' failing to pay what they owe to the clinician after a certified IDRE makes a payment determination that results in a balance owed to the clinician.

EDPMA members report that 87% of payers did not pay in accordance with the IDRE payment determination[xvii] *despite numerous attempts by clinicians to collect the payment. Some health plans are indicating that they are refusing to pay amounts owed after an IDRE's payment determination because they later disagree with the federal IDR eligibility determination*.

Most alarmingly, some health plans have written that they are refusing to pay amounts owed after an IDRE's payment determination because they do not agree with the decision or believe it is enforceable.

These assertions are occurring despite the health plan's refusal to provide RARC codes at the front end or other information during the IDR process that would clearly and proactively identify whether claims are or are not subject to the federal IDR process, as has been repeatedly requested by the clinician 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.**

To empower enforcement and compliance, the Departments should require that the comprehensive portal described in previous sections should include timestamped submission by either party of proof of payment made for any amounts owed following an IDR payment determination. 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 the clinician after the IDR process is completed must be penalized and forced to compensate the clinician the total amount owed, plus **interest and penalties**. Insurers continue to record profits quarter after quarter,[xviii] and any delay or lack of payment of the amounts they owe to clinicians under the *No Surprises Act* allows them to continue to accrue substantial one-sided benefits including additional interest on the amounts owed. This common practice cash-starves clinicians who provide timely access to emergency care and medical care to their members.

EDPMA recommends penalties shall be assessed to a non-compliant party as follows:

Interest. Once an IDR determination is made, the non-prevailing party must make up the difference with the prevailing party within 30 days, as per the statute. If such a payment is not made by the end of the 30-day period, interest should immediately apply. The Departments could consider setting the interest rate at the rate which HHS currently applies to overdue and delinquent debts, pursuant to 45 CFR Part 30—which is determined and fixed by the Secretary of the Treasury.

Penalties. Failure to pay certain fees associated with the IDR process and the IDRE should result in penalties as follows:

- Should the party owed funds not receive payment within the applicable timeframe, the party owed funds will attest to same. The Departments, via the portal, will automatically assess a penalty of $100 per item or service within each dispute. Additionally, the IDRE's payment determination will be increased by 25%.
- Should the prevailing party use small claims court/arbitration/etc. to procure payment on the IDRE payment determination, any fees associated with filing, including attorneys' fees, shall be reimbursed by the non-prevailing party. The court may, in its discretion, assess a penalty to the non-compliant party by increasing the IDRE payment determination by 50%.

EDPMA applauds your commitment and focus on the noble purpose of the *No Surprises Act to* protect patients from unexpected healthcare costs. You are a champion of the patient and the clinicians who care for them. We request that you consider our positions and requests and continue to work with the Departments to ensure the *No Surprises Act* is implemented as intended and to protect our country's healthcare safety net.

Sincerely,

Andrea Brault, MD, MMM, FACEP
Chair, Emergency Department Practice Management Association

cc: Senator Bernie Sanders, Chair, Senate HELP Committee
Senator Bill Cassidy, MD, Ranking Member, Senate HELP Committee
Rep. Jason Smith, Chair, House of Representatives Committee on Ways & Means
Rep. Richard Neal, Ranking Member, House of Representatives Committee on Ways & Means
Rep. Cathy McMorris-Rodgers, Chair, House of Representatives Energy & Commerce Committee
Rep. Frank Pallone, Jr. Ranking Member, House of Representatives Energy & Commerce Committee

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[i] 42 U.S.C. § 1395dd
[ii] 45 CFR § 147.138
[iii] CMS State Operations Manual – Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Care
[iv] Rand Study: The Evolving Rule of Emergency Departments In the United States, page 66
[v] Rand Study: The Evolving Role of Emergency Departments In the United States, page 66
[vi] American Family Physician: Medical Emergency Preparedness in Office Practice
[vii] The Rand Report: The Evolving Role of Emergency Departments In The United States: Page 70
[viii] EDPMA No Surprises Act Advocacy
[ix] EDPMA Data Analysis: Independent Dispute Resolution in the No Surprises Act – Deficiencies and Compliance Failures
[x] Federal Independent Dispute Resolution Process – Status Update: April 27, 2023
[xi] EDPMA Data Analysis: Independent Dispute Resolution in the No Surprises Act – Deficiencies and Compliance Failures
[xii] Federal Independent Dispute Resolution Process – Status Update: April 27, 2023
[xiii] Federal Independent Dispute Resolution Process – Status Update: April 27, 2023
[xiv] CMS Partial Report on the Independent Dispute Resolution (IDR) Process. October 1 – December 31, 2022
[xv] (45 CFR § 149.510(b)(1))
[xvi] EDPMA Data Analysis: Independent Dispute Resolution in the No Surprises Act – Deficiencies and Compliance Failures
[xvii] EDPMA Data Analysis: Independent Dispute Resolution in the No Surprises Act – Deficiencies and Compliance Failures
[xviii] National Association of Insurance Commissioners: U.S. Health Insurance Industry Analysis Report - 2021